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: 14-1313	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/26/2024 10:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/26/2024 Time: 10:49 am
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 MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Doug Kosier		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	Doug Kosier			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	187,758	271,775	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	177,949	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-10,534		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-3,187		0	10.01
10.02	RURAL HEALTH CLINIC III	0		5,568		0	10.02
200.00	TOTAL	0	365,707	263,622	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2024 10:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 615 NORTH PROMENADE STREET	PO Box:			1.00
2.00	City: HAVANA	State: IL	Zip Code: 62644-0530	County: MASON	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	MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	MANITO MEDICAL ASSOCIATES	148592	99914		04/19/2018	O	O	O	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)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2024 10:49 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	120,900	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N		123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2024 10:49 am

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/03/2024	Y	01/03/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2024 10:49 am

		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.	Y	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	MCCLUNG	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6414942144	DAVID.MCCLUNG@RSMUS.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2024 10:49 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	14,155.90	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	14,155.90	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00	Total (see instructions)		25	9,125	14,155.90	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2024 10:49 am

	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)	250	0	599			1.00
2.00	HMO and other (see instructions)	99	77				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	265	0	272			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	158			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	515	0	1,029			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	515	0	1,029	0.00	186.72	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,546	0	8,224	0.00	13.90	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,979	4,746	17,475	0.00	33.76	26.00
26.01	RURAL HEALTH CLINIC II	156	322	957	0.00	2.04	26.01
26.02	RURAL HEALTH CLINIC III	282	1,882	4,046	0.00	3.26	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	239.68	27.00
28.00	Observation Bed Days		0	251			28.00
29.00	Ambulance Trips	402					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2024 10:49 am

	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	71	23	155	1.00
2.00	HMO and other (see instructions)			26	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	71	23	155	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-4 | Date/Time Prepared: 2/26/2024 10:49 am

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	850	0	1,319	2,169	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	183.00	0.00	284.00	467.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.19	0.00	1.19	5.00
6.00	Direct Nursing Service			7.70	0.00	7.70	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.04	0.00	0.04	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.04	0.00	1.04	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					37900	20.00
20.01						44100	20.01
20.02						99914	20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,982	570	27	0	2,579	21.00
22.00	Skilled Nursing Visit Charges	651,971	187,530	8,883	0	848,384	22.00
23.00	Physical Therapy Visits	715	459	1	0	1,175	23.00
24.00	Physical Therapy Visit Charges	258,762	166,158	362	0	425,282	24.00
25.00	Occupational Therapy Visits	174	339	1	0	514	25.00
26.00	Occupational Therapy Visit Charges	62,988	122,356	362	0	185,706	26.00
27.00	Speech Pathology Visits	17	30	0	0	47	27.00
28.00	Speech Pathology Visit Charges	6,154	10,860	0	0	17,014	28.00
29.00	Medical Social Service Visits	1	1	0	0	2	29.00
30.00	Medical Social Service Visit Charges	362	362	0	0	724	30.00
31.00	Home Health Aide Visits	150	79	0	0	229	31.00
32.00	Home Health Aide Visit Charges	26,026	14,378	0	0	40,404	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,039	1,478	29	0	4,546	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,006,263	501,644	9,607	0	1,517,514	35.00
36.00	Total Number of Episodes (standard/non outlier)	383		20	0	403	36.00
37.00	Total Number of Outlier Episodes		84		0	84	37.00
38.00	Total Non-Routine Medical Supply Charges	7,520	684	0	0	8,204	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 10:49 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			615 N PROMENADE ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644-0530	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	18:00	08:00	11.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-3457

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

Worksheet S-8

Date/Time Prepared:
2/26/2024 10:49 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	18:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 10:49 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			122 EAST ELM STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MASON CITY		IL	62664	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	16:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	08:00	16:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-3462

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

Worksheet S-8

Date/Time Prepared:
2/26/2024 10:49 am

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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-8592 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 10:49 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1301 S. EAST AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MANITO		IL	61546	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	16:00	08:00	11.00

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

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

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

			County					
			4.00					
2.00	City, State, ZIP Code, County		MASON					2.00
		Tuesday	Wednesday		Thursday			
		to	from	to	from	to		
		6.00	7.00	8.00	9.00	10.00		
	Facility hours of operations (1)							
11.00	CLINIC	16:00	08:00	16:00	08:00	16:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-8592

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

Worksheet S-8

Date/Time Prepared:
2/26/2024 10:49 am

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	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1313	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/26/2024 10:49 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.531452	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	576,527	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	100,713	5.00
6.00	Medicaid charges	8,585,380	6.00
7.00	Medicaid cost (line 1 times line 6)	4,562,717	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,885,477	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	1,326,228	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,885,477	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	45,302	16,899	62,201	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	24,076	16,899	40,975	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	24,076	16,899	40,975	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	897,267	26.00
27.00	Medicare reimbursable bad debts (see instructions)	96,755	27.00
27.01	Medicare allowable bad debts (see instructions)	148,855	27.01
28.00	Non-Medicare bad debt amount (see instructions)	748,412	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	449,845	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	490,820	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,376,297	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1313	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/26/2024 10:49 am

			1.00	
	PART II - HOSPITAL DATA			
	Uncompensated and Indigent Care Cost-to-Charge Ratio			
1.00	Cost to charge ratio (see instructions)			1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
	Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	451,338	451,338	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	43,592	43,592	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	295,488	295,488	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI		0	0	46,740	46,740	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,620,635	1,620,635	-708,861	911,774	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,151,380	4,151,380	0	4,151,380	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	856,357	1,387,944	2,244,301	0	2,244,301	5.01
5.02	00591	A&G HOSPITAL ONLY	485,253	313,528	798,781	0	798,781	5.02
6.00	00600	MAINTENANCE & REPAIRS	318,808	289,744	608,552	0	608,552	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	353,434	353,434	0	353,434	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	32,773	32,773	0	32,773	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	33,014	33,014	0	33,014	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,597	23,996	53,593	0	53,593	8.00
9.00	00900	HOUSEKEEPING	370,795	97,720	468,515	0	468,515	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	283,413	295,910	579,323	0	579,323	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	177,798	17,618	195,416	0	195,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,979	15,497	129,476	0	129,476	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,644	68,333	240,977	0	240,977	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	356,095	356,095	0	356,095	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,272,133	632,007	1,904,140	0	1,904,140	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	192,942	142,937	335,879	0	335,879	50.00
53.00	05300	ANESTHESIOLOGY	0	5,599	5,599	0	5,599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	704,485	521,681	1,226,166	-125,611	1,100,555	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	77,238	66,867	144,105	5,710	149,815	54.01
56.00	05600	RADIOISOTOPE	0	131,473	131,473	386	131,859	56.00
58.00	05800	MRI	0	160,185	160,185	2,217	162,402	58.00
60.00	06000	LABORATORY	810,503	1,125,381	1,935,884	97,910	2,033,794	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	129,410	129,410	0	129,410	62.00
64.00	06400	INTRAVENOUS THERAPY	0	26,710	26,710	0	26,710	64.00
66.00	06600	PHYSICAL THERAPY	743,836	211,262	955,098	0	955,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,623	51,314	357,937	0	357,937	67.00
68.00	06800	SPEECH PATHOLOGY	99,725	11,228	110,953	0	110,953	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	492,442	120,367	612,809	19,388	632,197	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	470,839	470,839	0	470,839	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	478,125	641,652	1,119,777	0	1,119,777	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	202,583	180,566	383,149	0	383,149	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	14,697	4,963	19,660	0	19,660	76.02
76.03	03951	WOUND CARE	0	138,890	138,890	0	138,890	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,307,363	1,715,778	5,023,141	-47,875	4,975,266	88.00
88.01	08801	RURAL HEALTH CLINIC II	129,123	72,268	201,391	0	201,391	88.01
88.02	08802	RURAL HEALTH CLINIC III	636,418	191,346	827,764	0	827,764	88.02
91.00	09100	EMERGENCY	634,244	1,762,484	2,396,728	862,003	3,258,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,292,249	145,721	1,437,970	-862,003	575,967	95.00
101.00	10100	HOME HEALTH AGENCY	695,694	195,878	891,572	0	891,572	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		128,297	128,297	-128,297	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,899,067	18,042,724	32,941,791	-47,875	32,893,916	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	11,562	12,144	23,706	47,875	71,581	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/26/2024 10:49 am

	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	
200.00	TOTAL (SUM OF LINES 118 through 199)	14,910,629	18,054,868	32,965,497	0	32,965,497	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/26/2024 10:49 am

		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	-48,378	402,960		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	43,592		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-67,501	227,987		1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI	0	46,740		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	911,774		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,239,416	2,911,964		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-45,204	2,199,097		5.01
5.02	00591	A&G HOSPITAL ONLY	0	798,781		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	608,552		6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0		6.01
7.00	00700	OPERATION OF PLANT	-397	353,037		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	32,773		7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	33,014		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,593		8.00
9.00	00900	HOUSEKEEPING	0	468,515		9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0		9.01
10.00	01000	DIETARY	-149,685	429,638		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	195,416		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	129,476		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,797	238,180		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-51,416	304,679		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-351,940	1,552,200		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-11,430	324,449		50.00
53.00	05300	ANESTHESIOLOGY	0	5,599		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,155	1,099,400		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	149,815		54.01
56.00	05600	RADIOISOTOPE	0	131,859		56.00
58.00	05800	MRI	0	162,402		58.00
60.00	06000	LABORATORY	0	2,033,794		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	129,410		62.00
64.00	06400	INTRAVENOUS THERAPY	0	26,710		64.00
66.00	06600	PHYSICAL THERAPY	0	955,098		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	357,937		67.00
68.00	06800	SPEECH PATHOLOGY	0	110,953		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	-25,861	606,336		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	470,839		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-182,655	937,122		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	383,149		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	19,660		76.02
76.03	03951	WOUND CARE	-55,280	83,610		76.03
76.04	03953	ALLERGY 123	0	0		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,975,266		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	201,391		88.01
88.02	08802	RURAL HEALTH CLINIC III	-300	827,464		88.02
91.00	09100	EMERGENCY	-194,780	3,063,951		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	575,967		95.00
101.00	10100	HOME HEALTH AGENCY	0	891,572		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,428,195	30,465,721		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	71,581		192.00
194.00	07950	HOSPICE	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,428,195	30,537,302		200.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/26/2024 10:49 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,268		1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	81,029		2.00
	0		0	128,297		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	862,003	0		1.00
	0		862,003	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	404,070		1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	43,592		2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	214,459		3.00
4.00	NEW CAP REL COSTS - WEST CAMPUS BUI	1.03	0	46,740		4.00
	0		0	708,861		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	47,875	0		1.00
	0		47,875	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	86,027	11,883		1.00
2.00	CARDIOPULMONARY	69.01	17,035	2,353		2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	5,017	693		3.00
4.00	RADIOISOTOPE	56.00	339	47		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	7,798	1,077		5.00
6.00	MRI	58.00	1,948	269		6.00
	0		118,164	16,322		
500.00	Grand Total: Increases		1,028,042	853,480		500.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/26/2024 10:49 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	128,297	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	128,297			
	B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	862,003	0	0		1.00
	0		862,003	0			
	C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	708,861	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
	0		0	708,861			
	D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	47,875	0	0		1.00
	0		47,875	0			
	E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	118,164	16,322	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		118,164	16,322			
500.00	Grand Total: Decreases		1,028,042	853,480			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2024 10:49 am

		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	163,928	0	0	0	0	1.00
2.00	Land Improvements	674,756	19,995	0	19,995	0	2.00
3.00	Buildings and Fixtures	19,098,000	574,121	0	574,121	0	3.00
4.00	Building Improvements	96,997	0	0	0	0	4.00
5.00	Fixed Equipment	3,907,604	0	0	0	0	5.00
6.00	Movable Equipment	12,038,325	1,005,506	0	1,005,506	0	6.00
7.00	HIT designated Assets	1,231,920	146,188	0	146,188	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,211,530	1,745,810	0	1,745,810	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,211,530	1,745,810	0	1,745,810	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	163,928	0	1.00
2.00	Land Improvements	694,751	0	2.00
3.00	Buildings and Fixtures	19,672,121	0	3.00
4.00	Building Improvements	96,997	0	4.00
5.00	Fixed Equipment	3,907,604	0	5.00
6.00	Movable Equipment	13,043,831	0	6.00
7.00	HIT designated Assets	1,378,108	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,957,340	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	38,957,340	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	0	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	1,620,635	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,620,635	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,620,635	2.00
3.00	Total (sum of lines 1-2)	0	1,620,635	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	24,535,401	0	24,535,401	0.629802	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	0	0.000000	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	14,421,939	0	14,421,939	0.370198	0	2.00
3.00	Total (sum of lines 1-2)	38,957,340	0	38,957,340	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	391,860	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	43,592	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	213,257	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	0	46,740	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	911,774	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,607,223	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,100	402,960	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	43,592	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	14,730	0	0	0	227,987	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	0	0	46,740	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	911,774	2.00
3.00	Total (sum of lines 1-2)	14,730	0	0	11,100	1,633,053	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
1.03	Investment income - NEW CAP REL COSTS - WEST CAMPUS BUI (chapter 2)		0	NEW CAP REL COSTS - WEST CAMPUS BUI	1.03	0	1.03
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-640,446			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS - WEST CAMPUS BUI		0	NEW CAP REL COSTS - WEST CAMPUS BUI	1.03	0	26.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/26/2024 10:49 am

	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	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	B	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-2,797	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-149,685	DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B	0	DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	1,998	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	ON-CALL CRNA SERVICES	A	-51,416	NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-12,210	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	MISCELLANEOUS -OTHER OP	B	-14,004	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	RENTAL INCOME	B	0	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	COMMUNITY ED FEES -OTHER OP	B	0	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	LAB OUTREACH REV -OTHER OP	B	0	LABORATORY	60.00	0	33.09
33.10	INTEREST INCOME -NON OPER	B	-47,268	CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	INTEREST INCOME -NON OPER	B	-66,299	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.11
33.12	FITNESS EXPENSE	A	0	CARDIOPULMONARY	69.01	0	33.12
33.13	FITNESS CENTER REV	B	0	CARDIOPULMONARY	69.01	0	33.13
33.14	HOME HEALTH REV	B	0	HOME HEALTH AGENCY	101.00	0	33.14
33.15	TELEPHONE OFFSET - OPERATIONS	A	-397	OPERATION OF PLANT	7.00	0	33.15
33.16	TELEPHONE OFFSET - SALARIES	A	-110	ADMINISTRATIVE AND GENERAL	5.01	0	33.16
33.17	TELEPHONE OFFSET - BENEFITS	A	-25	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	MEDICAR - EXPENSES	A	-8,575	ADMINISTRATIVE AND GENERAL	5.01	0	33.18
33.19	MEDICAR - BENEFITS	A	-1,525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	LOBBYING DUES	A	-7,770	ADMINISTRATIVE AND GENERAL	5.01	0	33.20
33.21	ADVERTISING	A	-16,743	ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A	0	A&G HOSPITAL ONLY	5.02	0	33.22
33.25	ADVERTISING	A	-300	RURAL HEALTH CLINIC III	88.02	0	33.25
33.27	SPEECH THERAPY IN SCHOOLS	B	0	SPEECH PATHOLOGY	68.00	0	33.27
33.34	SPEECH THERAPY IN SCHOOLS	B	0	SPEECH PATHOLOGY	68.00	0	33.34
33.35	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.35
33.36	SELF INSURANCE	A	-598,367	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-107,566	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38	NON-ALLOW DONATION EXP	A	0	ADMINISTRATIVE AND GENERAL	5.01	0	33.38
33.39	BOND AMORTIZTION COST FY14	A	11,100	CAP REL COSTS-BLDG & FIXT	1.00	14	33.39
33.40	IMRF CONTRIBUTION	A	-531,933	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
33.41	340 B	A	-182,655	DRUGS CHARGED TO PATIENTS	73.00	0	33.41
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,428,195				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2024 10:49 am

	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	1,607,424	194,780	1,412,644	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	25,861	25,861	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,155	1,155	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	351,940	351,940	0	0	0	5.00
6.00	76.03	WOUND CARE	138,200	55,280	82,920	0	0	6.00
7.00	50.00	OPERATING ROOM	11,430	11,430	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			2,184,010	640,446	1,543,564		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	76.03	WOUND CARE	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	194,780		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	25,861		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,155		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	351,940		5.00
6.00	76.03	WOUND CARE	0	0	0	55,280		6.00
7.00	50.00	OPERATING ROOM	0	0	0	11,430		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	640,446		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUI	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	402,960	402,960				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	43,592	0	43,592			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	227,987	0	0	227,987		1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI	46,740	0	0	0	46,740	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	911,774					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,911,964	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	2,199,097	89,319	2,313	0	0	5.01
5.02	00591	A&G HOSPITAL ONLY	798,781	9,141	2,848	1,871	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	608,552	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	353,037	39,907	365	4,990	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	32,773	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	33,014	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	53,593	12,014	0	1,855	0	8.00
9.00	00900	HOUSEKEEPING	468,515	2,665	0	1,096	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	429,638	19,530	0	0	0	10.00
11.00	01100	CAFETERIA	0	8,302	0	1,264	0	11.00
13.00	01300	NURSING ADMINISTRATION	195,416	6,099	0	2,714	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	129,476	11,097	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,180	5,483	443	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	304,679	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,552,200	5,938	0	177,730	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	324,449	48,070	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	5,599	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,099,400	37,474	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	149,815	1,871	0	0	0	54.01
56.00	05600	RADIOISOTOPE	131,859	4,066	0	0	0	56.00
58.00	05800	MRI	162,402	0	0	0	0	58.00
60.00	06000	LABORATORY	2,033,794	22,025	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,410	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	26,710	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	955,098	7,932	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	357,937	1,663	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	110,953	1,201	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	606,336	37,689	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	470,839	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	937,122	0	0	31,527	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	383,149	0	1,855	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	19,660	0	0	0	0	76.02
76.03	03951	WOUND CARE	83,610	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,975,266	0	31,991	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	201,391	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	827,464	0	0	0	0	88.02
91.00	09100	EMERGENCY	3,063,951	31,474	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	575,967	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	891,572	0	3,777	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,465,721	402,960	43,592	223,047	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,940	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	71,581	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUI	
			0	1.00	1.01	1.02	1.03	
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	46,740	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,537,302	402,960	43,592	227,987	46,740	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	
			2.00	4.00	4A	5.01	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	911,774					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,911,964				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	227,115	172,851	2,690,695	2,690,695		5.01
5.02	00591	A&G HOSPITAL ONLY	0	98,133	910,774	88,004	998,778	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	64,473	673,025	65,032	738,057	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	12,218	0	410,517	39,667	450,184	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	32,773	3,167	35,940	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	33,014	3,190	36,204	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,985	73,447	7,097	80,544	8.00
9.00	00900	HOUSEKEEPING	0	74,986	547,262	52,880	600,142	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	57,315	506,483	48,939	555,422	10.00
11.00	01100	CAFETERIA	0	0	9,566	924	10,490	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,956	240,185	23,208	263,393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,050	163,623	15,810	179,433	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,400	34,914	332,420	32,120	364,540	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	304,679	29,440	334,119	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,694	257,265	2,013,827	194,588	2,208,415	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,556	39,019	520,094	50,255	570,349	50.00
53.00	05300	ANESTHESIOLOGY	0	0	5,599	541	6,140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,679	120,149	1,523,702	147,229	1,670,931	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	16,635	168,321	16,264	184,585	54.01
56.00	05600	RADIOISOTOPE	0	0	135,925	13,134	149,059	56.00
58.00	05800	MRI	0	394	162,796	15,730	178,526	58.00
60.00	06000	LABORATORY	42,834	181,306	2,279,959	220,303	2,500,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	129,410	12,504	141,914	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	26,710	2,581	29,291	64.00
66.00	06600	PHYSICAL THERAPY	63,108	150,427	1,176,565	113,687	1,290,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62,009	421,609	40,738	462,347	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,167	132,321	12,786	145,107	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	644,025	62,230	706,255	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	470,839	45,495	516,334	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,692	1,065,341	102,940	1,168,281	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	40,969	425,973	41,160	467,133	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	2,972	22,632	2,187	24,819	76.02
76.03	03951	WOUND CARE	0	0	83,610	8,079	91,689	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,182	659,173	5,695,612	550,333	6,245,945	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,592	26,113	229,096	22,137	251,233	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	128,703	956,167	92,391	1,048,558	88.02
91.00	09100	EMERGENCY	14,318	302,588	3,412,331	329,720	3,742,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	64,331	87,009	727,307	70,277	797,584	95.00
101.00	10100	HOME HEALTH AGENCY	7,747	140,691	1,043,787	100,857	1,144,644	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	911,774	2,899,944	30,402,021	2,677,624	30,388,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,940	477	5,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,020	83,601	8,078	91,679	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	46,740	4,516	51,256	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	
			2.00	4.00	4A	5.01	5A.01	
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	911,774	2,911,964	30,537,302	2,690,695	30,537,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	
			5.02	6.00	6.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY	998,778					5.02
6.00	00600	MAINTENANCE & REPAIRS	33,886	771,943				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0			6.01
7.00	00700	OPERATION OF PLANT	20,669	62,852	0	533,705		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	1,650	0	0	0	37,590	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	1,662	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,698	18,626	0	18,763	0	8.00
9.00	00900	HOUSEKEEPING	27,554	4,598	0	4,632	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	25,501	28,301	0	28,510	0	10.00
11.00	01100	CAFETERIA	482	12,867	0	12,962	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,093	10,635	0	10,714	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,238	16,081	0	16,200	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,737	10,033	0	8,004	486	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	15,340	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,395	126,250	0	127,180	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,186	69,659	0	70,173	0	50.00
53.00	05300	ANESTHESIOLOGY	282	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,717	54,303	0	54,704	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	8,475	2,712	0	2,732	0	54.01
56.00	05600	RADIOISOTOPE	6,844	5,892	0	5,936	0	56.00
58.00	05800	MRI	8,197	0	0	0	0	58.00
60.00	06000	LABORATORY	114,795	31,917	0	32,152	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,516	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,345	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	59,239	11,495	0	11,579	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,228	2,411	0	2,428	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,662	1,741	0	1,754	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	32,426	54,616	0	55,019	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,706	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,639	20,869	0	21,023	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	21,447	8,738	0	0	2,034	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	1,140	0	0	0	0	76.02
76.03	03951	WOUND CARE	4,210	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	150,678	0	0	35,070	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	48,142	0	0	0	0	88.02
91.00	09100	EMERGENCY	171,809	45,610	0	45,946	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	36,619	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	17,789	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	998,529	768,673	0	530,411	37,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	249	3,270	0	3,294	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	
		5.02	6.00	6.01	7.00	7.01	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	998,778	771,943	0	533,705	37,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	OPERATION OF PLANT - WEST CAMPUS BU	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	
			7.02	8.00	9.00	9.01	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	37,866					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,631				8.00
9.00	00900	HOUSEKEEPING	0	0	636,926			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0		9.01
10.00	01000	DIETARY	0	0	26,282	0	664,016	10.00
11.00	01100	CAFETERIA	0	0	11,949	0	539,884	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	9,876	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14,934	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	9,317	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,101	117,241	0	96,784	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,320	64,689	0	6,420	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,772	50,428	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	2,518	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	5,472	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	78	29,639	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	6,885	10,674	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,239	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,617	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,423	50,719	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	19,380	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	8,115	0	19,491	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	758	139,927	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	165	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	32,651	42,355	0	1,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	315	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	145	16,519	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	121,613	633,890	0	664,016	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,036	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	37,866	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	OPERATION OF PLANT - WEST CAMPUS BU	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	
		7.02	8.00	9.00	9.01	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	37,866	121,631	636,926	0	664,016	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		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
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	588,634					11.00
13.00	01300	NURSING ADMINISTRATION	5,875	312,586				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,458	0	245,344			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,829	0	0	0	420,946	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,534	180,868	0	0	22,010	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,534	33,306	0	0	13,231	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,503	0	4,500	0	72,035	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4,661	0	268	0	8,767	54.01
56.00	05600	RADIOISOTOPE	39	0	4,079	0	3,374	56.00
58.00	05800	MRI	235	0	378	0	14,370	58.00
60.00	06000	LABORATORY	63,689	0	124,982	0	76,288	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	23,474	0	1,173	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	2,258	0	4,498	64.00
66.00	06600	PHYSICAL THERAPY	34,195	0	0	0	30,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,511	0	0	0	12,386	67.00
68.00	06800	SPEECH PATHOLOGY	3,995	0	0	0	3,041	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	29,925	0	0	0	11,829	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	85,405	0	5,438	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,410	0	0	0	9,033	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	13,318	22,894	0	0	8,932	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	588	0	0	0	4	76.02
76.03	03951	WOUND CARE	0	0	0	0	5,261	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	131,844	0	0	0	37,048	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,732	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	7,472	88.02
91.00	09100	EMERGENCY	114,491	75,518	0	0	23,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	20,550	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	20,576	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	588,634	312,586	245,344	0	420,946	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	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	588,634	312,586	245,344	0	420,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	349,459					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,106,778	0	3,106,778		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	880,867	0	880,867		50.00
53.00	05300	ANESTHESIOLOGY	349,459	363,945	0	363,945		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,038,893	0	2,038,893		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	214,718	0	214,718		54.01
56.00	05600	RADIOISOTOPE	0	180,695	0	180,695		56.00
58.00	05800	MRI	0	201,706	0	201,706		58.00
60.00	06000	LABORATORY	0	2,973,802	0	2,973,802		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	173,077	0	173,077		62.00
64.00	06400	INTRAVENOUS THERAPY	0	37,392	0	37,392		64.00
66.00	06600	PHYSICAL THERAPY	0	1,454,938	0	1,454,938		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	518,550	0	518,550		67.00
68.00	06800	SPEECH PATHOLOGY	0	163,917	0	163,917		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	942,212	0	942,212		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	630,883	0	630,883		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,310,635	0	1,310,635		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	572,102	0	572,102		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	26,551	0	26,551		76.02
76.03	03951	WOUND CARE	0	101,160	0	101,160		76.03
76.04	03953	ALLERGY 123	0	0	0	0		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,741,270	0	6,741,270		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	253,130	0	253,130		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,104,172	0	1,104,172		88.02
91.00	09100	EMERGENCY	0	4,295,083	0	4,295,083		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	855,068	0	855,068		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,199,673	0	1,199,673		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	349,459	30,341,217	0	30,341,217		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,266	0	15,266		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	91,697	0	91,697		192.00
194.00	07950	HOSPICE	0	0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	89,122	0	89,122		194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	349,459	30,537,302	0	30,537,302		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUI	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	89,319	2,313	0	0	5.01
5.02	00591	A&G HOSPITAL ONLY	0	9,141	2,848	1,871	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	39,907	365	4,990	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,014	0	1,855	0	8.00
9.00	00900	HOUSEKEEPING	0	2,665	0	1,096	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	19,530	0	0	0	10.00
11.00	01100	CAFETERIA	0	8,302	0	1,264	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,099	0	2,714	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,097	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,483	443	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,938	0	177,730	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,070	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,474	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,871	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,066	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	22,025	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,932	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,663	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,201	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	37,689	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,527	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,855	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	31,991	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	31,474	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,777	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	402,960	43,592	223,047	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,940	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUI	
			0	1.00	1.01	1.02	1.03	
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	46,740	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	402,960	43,592	227,987	46,740	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	
			2.00	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	227,115	318,747	0	318,747		5.01
5.02	00591	A&G HOSPITAL ONLY	0	13,860	0	10,426	24,286	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	7,704	824	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	12,218	57,480	0	4,699	502	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	375	40	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	0	378	40	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,869	0	841	90	8.00
9.00	00900	HOUSEKEEPING	0	3,761	0	6,265	670	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	19,530	0	5,798	620	10.00
11.00	01100	CAFETERIA	0	9,566	0	110	12	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,813	0	2,749	294	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,097	0	1,873	200	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,400	59,326	0	3,805	407	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	3,488	373	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,694	204,362	0	23,052	2,465	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,556	156,626	0	5,954	637	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	64	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,679	304,153	0	17,442	1,865	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,871	0	1,927	206	54.01
56.00	05600	RADIOISOTOPE	0	4,066	0	1,556	166	56.00
58.00	05800	MRI	0	0	0	1,864	199	58.00
60.00	06000	LABORATORY	42,834	64,859	0	26,099	2,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,481	158	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	306	33	64.00
66.00	06600	PHYSICAL THERAPY	63,108	71,040	0	13,468	1,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,663	0	4,826	516	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,201	0	1,515	162	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	37,689	0	7,372	788	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,390	576	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,527	0	12,195	1,304	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,855	0	4,876	521	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	259	28	76.02
76.03	03951	WOUND CARE	0	0	0	957	102	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,182	61,173	0	65,183	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,592	1,592	0	2,622	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	10,945	1,170	88.02
91.00	09100	EMERGENCY	14,318	45,792	0	39,061	4,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	64,331	64,331	0	8,325	890	95.00
101.00	10100	HOME HEALTH AGENCY	7,747	11,524	0	11,948	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	911,774	1,581,373	0	317,198	24,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,940	0	57	6	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	957	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	46,740	0	535	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	
			2.00	2A	4.00	5.01	5.02	
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	911,774	1,633,053	0	318,747	24,286	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BU	
			6.00	6.01	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	8,528					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0				6.01
7.00	00700	OPERATION OF PLANT	694	0	63,375			7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	415		7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	0	0	418	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	206	0	2,228	0	0	8.00
9.00	00900	HOUSEKEEPING	51	0	550	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	313	0	3,385	0	0	10.00
11.00	01100	CAFETERIA	142	0	1,539	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	117	0	1,272	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	178	0	1,924	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111	0	950	5	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,395	0	15,104	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	770	0	8,333	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	600	0	6,496	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	30	0	324	0	0	54.01
56.00	05600	RADIOISOTOPE	65	0	705	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	353	0	3,818	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	127	0	1,375	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27	0	288	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19	0	208	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	603	0	6,533	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231	0	2,496	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97	0	0	22	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,662	0	0	388	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	504	0	5,456	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	197	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,492	0	62,984	415	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36	0	391	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	418	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BU	
		6.00	6.01	7.00	7.01	7.02	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	8,528	0	63,375	415	418	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	
			8.00	9.00	9.01	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	17,234					8.00
9.00	00900	HOUSEKEEPING	0	11,297				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0			9.01
10.00	01000	DIETARY	0	466	0	30,112		10.00
11.00	01100	CAFETERIA	0	212	0	24,483	36,064	11.00
13.00	01300	NURSING ADMINISTRATION	0	175	0	0	360	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	265	0	0	641	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	165	0	0	725	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,816	2,079	0	4,389	4,812	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,029	1,147	0	291	768	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,376	894	0	0	2,359	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	45	0	0	286	54.01
56.00	05600	RADIOISOTOPE	0	97	0	0	2	56.00
58.00	05800	MRI	0	0	0	0	14	58.00
60.00	06000	LABORATORY	11	526	0	0	3,902	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	975	189	0	0	2,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40	0	0	950	67.00
68.00	06800	SPEECH PATHOLOGY	0	29	0	0	245	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	202	900	0	0	1,833	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	344	0	0	1,128	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	144	0	884	816	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	36	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	107	2,482	0	0	8,077	88.00
88.01	08801	RURAL HEALTH CLINIC II	23	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,626	751	0	65	7,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	45	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	21	293	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,231	11,243	0	30,112	36,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	
		8.00	9.00	9.01	10.00	11.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	17,234	11,297	0	30,112	36,064	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,780					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,178				14.00
15.00	01500	PHARMACY	0	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	65,494		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	3,861	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,974	0	0	3,424		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,468	0	0	2,058		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,255		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	297	0	11,206		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	18	0	1,364		54.01
56.00	05600	RADIOISOTOPE	0	269	0	525		56.00
58.00	05800	MRI	0	25	0	2,235		58.00
60.00	06000	LABORATORY	0	8,240	0	11,875		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,548	0	183		62.00
64.00	06400	INTRAVENOUS THERAPY	0	149	0	700		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,763		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,927		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	473		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,840		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,632	0	846		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,405		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,009	0	0	1,390		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	1		76.02
76.03	03951	WOUND CARE	0	0	0	818		76.03
76.04	03953	ALLERGY 123	0	0	0	0		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,764		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	270		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,162		88.02
91.00	09100	EMERGENCY	3,329	0	0	3,612		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,197		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	3,201		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,780	16,178	0	65,494	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPICE	0	0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0		194.04
200.00		Cross Foot Adjustments					3,861	200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	19.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	13,780	16,178	0	65,494	3,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS					6.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING					9.01
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
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	275,872	0	275,872		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	180,081	0	180,081		50.00
53.00	05300	ANESTHESIOLOGY	1,326	0	1,326		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	347,688	0	347,688		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,071	0	6,071		54.01
56.00	05600	RADIOISOTOPE	7,451	0	7,451		56.00
58.00	05800	MRI	4,337	0	4,337		58.00
60.00	06000	LABORATORY	122,473	0	122,473		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,370	0	3,370		62.00
64.00	06400	INTRAVENOUS THERAPY	1,188	0	1,188		64.00
66.00	06600	PHYSICAL THERAPY	95,472	0	95,472		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,237	0	10,237		67.00
68.00	06800	SPEECH PATHOLOGY	3,852	0	3,852		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	57,760	0	57,760		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,444	0	12,444		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,630	0	50,630		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,614	0	11,614		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	324	0	324		76.02
76.03	03951	WOUND CARE	1,877	0	1,877		76.03
76.04	03953	ALLERGY 123	0	0	0		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	144,836	0	144,836		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,507	0	4,507		88.01
88.02	08802	RURAL HEALTH CLINIC III	13,277	0	13,277		88.02
91.00	09100	EMERGENCY	114,396	0	114,396		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	76,788	0	76,788		95.00
101.00	10100	HOME HEALTH AGENCY	27,184	0	27,184		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,575,055	0	1,575,055		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,484	0	5,484		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	960	0	960		192.00
194.00	07950	HOSPICE	0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	47,693	0	47,693		194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0		194.04
200.00		Cross Foot Adjustments	3,861	0	3,861		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,633,053	0	1,633,053		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUI (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,325					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	0	21,089		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					984,291	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,598	976	0	0	245,178	5.01
5.02	00591	A&G HOSPITAL ONLY	1,187	1,202	111	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	5,182	154	296	0	13,190	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	0	0	8.00
9.00	00900	HOUSEKEEPING	346	0	65	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	0	0	0	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712	187	0	0	57,647	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	0	22,340	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	0	0	117,190	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	0	0	287,888	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	0	0	46,241	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	0	68,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	0	31,503	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,719	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	0	0	15,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	69,448	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	0	8,363	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,325	18,398	13,230	0	984,291	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUI (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	21,089	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	402,960	43,592	227,987	46,740	911,774	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.701099	2.369388	16.859203	2.216321	0.926326	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
			4.00	5A.01	5.01	5A.02	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,399,178					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	854,721	-2,690,695	27,846,607			5.01
5.02	00591	A&G HOSPITAL ONLY	485,253	0	910,774	-998,778	21,753,767	5.02
6.00	00600	MAINTENANCE & REPAIRS	318,808	0	673,025	0	738,057	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	0	410,517	0	450,184	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	32,773	0	35,940	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	33,014	0	36,204	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,597	0	73,447	0	80,544	8.00
9.00	00900	HOUSEKEEPING	370,795	0	547,262	0	600,142	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	283,413	0	506,483	0	555,422	10.00
11.00	01100	CAFETERIA	0	0	9,566	0	10,490	11.00
13.00	01300	NURSING ADMINISTRATION	177,798	0	240,185	0	263,393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,979	0	163,623	0	179,433	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,644	0	332,420	0	364,540	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	304,679	0	334,119	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,272,133	0	2,013,827	0	2,208,415	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	192,942	0	520,094	0	570,349	50.00
53.00	05300	ANESTHESIOLOGY	0	0	5,599	0	6,140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,120	0	1,523,702	0	1,670,931	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	82,255	0	168,321	0	184,585	54.01
56.00	05600	RADIOISOTOPE	0	0	135,925	0	149,059	56.00
58.00	05800	MRI	1,948	0	162,796	0	178,526	58.00
60.00	06000	LABORATORY	896,530	0	2,279,959	0	2,500,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	129,410	0	141,914	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	26,710	0	29,291	64.00
66.00	06600	PHYSICAL THERAPY	743,836	0	1,176,565	0	1,290,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,623	0	421,609	0	462,347	67.00
68.00	06800	SPEECH PATHOLOGY	99,725	0	132,321	0	145,107	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	644,025	0	706,255	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	470,839	0	516,334	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	478,125	0	1,065,341	0	1,168,281	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	202,583	0	425,973	0	467,133	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	14,697	0	22,632	0	24,819	76.02
76.03	03951	WOUND CARE	0	0	83,610	0	91,689	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,259,488	0	5,695,612	-6,245,945	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	129,123	0	229,096	-251,233	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	636,418	0	956,167	0	1,048,558	88.02
91.00	09100	EMERGENCY	1,496,247	0	3,412,331	0	3,742,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	430,246	0	727,307	0	797,584	95.00
101.00	10100	HOME HEALTH AGENCY	695,694	0	1,043,787	-1,144,644	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,339,741	-2,690,695	27,711,326	-8,640,600	21,748,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,940	0	5,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,437	0	83,601	-91,679	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	46,740	-51,256	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
			4.00	5A.01	5.01	5A.02	5.02	
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	2,911,964		2,690,695		998,778	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.202231		0.096626		0.045913	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		318,747		24,286	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.011447		0.001116	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BU (SQUARE FEET)	
			6.00	6.01	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	69,172					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	21,089				6.01
7.00	00700	OPERATION OF PLANT	5,632	0	47,474			7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	14,472		7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU	0	0	0	0	21,089	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	1,669	0	0	8.00
9.00	00900	HOUSEKEEPING	412	0	412	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	2,536	0	0	10.00
11.00	01100	CAFETERIA	1,153	0	1,153	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	953	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	1,441	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	899	0	712	187	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,313	0	11,313	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	6,242	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	4,866	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	243	0	0	54.01
56.00	05600	RADIOISOTOPE	528	0	528	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	2,860	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,030	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	4,894	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	1,870	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	783	0	0	783	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,502	0	0	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	4,087	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,594	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,879	0	47,181	14,472	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	21,089	0	0	21,089	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BU (SQUARE FEET)	
		6.00	6.01	7.00	7.01	7.02	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	771,943	0	533,705	37,590	37,866	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.159761	0.000000	11.242048	2.597430	1.795533	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	8,528	0	63,375	415	418	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.123287	0.000000	1.334941	0.028676	0.019821	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			8.00	9.00	9.01	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	67,117					8.00
9.00	00900	HOUSEKEEPING	0	61,459				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	21,089			9.01
10.00	01000	DIETARY	0	2,536	0	34,647		10.00
11.00	01100	CAFETERIA	0	1,153	0	28,170	15,028	11.00
13.00	01300	NURSING ADMINISTRATION	0	953	0	0	150	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,441	0	0	267	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	899	0	0	302	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,543	11,313	0	5,050	2,005	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,902	6,242	0	335	320	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,255	4,866	0	0	983	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	243	0	0	119	54.01
56.00	05600	RADIOISOTOPE	0	528	0	0	1	56.00
58.00	05800	MRI	0	0	0	0	6	58.00
60.00	06000	LABORATORY	43	2,860	0	0	1,626	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,799	1,030	0	0	873	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216	0	0	396	67.00
68.00	06800	SPEECH PATHOLOGY	0	156	0	0	102	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	785	4,894	0	0	764	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,870	0	0	470	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	1,017	340	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	15	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	418	13,502	0	0	3,366	88.00
88.01	08801	RURAL HEALTH CLINIC II	91	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	18,017	4,087	0	75	2,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	174	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	80	1,594	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,107	61,166	0	34,647	15,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	293	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	21,089	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		8.00	9.00	9.01	10.00	11.00	
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)	121,631	636,926	0	664,016	588,634	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.812223	10.363429	0.000000	19.165180	39.169151	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,234	11,297	0	30,112	36,064	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.256775	0.183814	0.000000	0.869108	2.399787	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BU						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	48,156					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,352,577				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	57,091,159		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,864	0	0	2,985,235	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,131	0	0	1,794,476	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,093,731	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,810	0	9,770,125	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,475	0	1,189,104	0	54.01
56.00	05600	RADIOISOTOPE	0	22,485	0	457,597	0	56.00
58.00	05800	MRI	0	2,085	0	1,948,954	0	58.00
60.00	06000	LABORATORY	0	689,025	0	10,344,919	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	129,410	0	159,135	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	12,448	0	610,005	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,152,803	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,679,959	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	412,480	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,604,405	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	470,839	0	737,590	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	1,225,079	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,527	0	0	1,211,455	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	587	0	76.02
76.03	03951	WOUND CARE	0	0	0	713,570	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,024,882	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	234,963	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,013,434	0	88.02
91.00	09100	EMERGENCY	11,634	0	0	3,148,677	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,787,217	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,790,777	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,156	1,352,577	100	57,091,159	100	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	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 10:49 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	312,586	245,344	0	420,946	349,459	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.491112	0.181390	0.000000	0.007373	3,494.590000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,780	16,178	0	65,494	3,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.286153	0.011961	0.000000	0.001147	38.610000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,106,778		3,106,778	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	880,867		880,867	0	0	50.00
53.00	05300	ANESTHESIOLOGY	363,945		363,945	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,038,893		2,038,893	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	214,718		214,718	0	0	54.01
56.00	05600	RADIOISOTOPE	180,695		180,695	0	0	56.00
58.00	05800	MRI	201,706		201,706	0	0	58.00
60.00	06000	LABORATORY	2,973,802		2,973,802	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	173,077		173,077	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	37,392		37,392	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,454,938	0	1,454,938	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,550	0	518,550	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	163,917	0	163,917	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	942,212		942,212	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	630,883		630,883	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,635		1,310,635	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	572,102		572,102	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0		0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	26,551		26,551	0	0	76.02
76.03	03951	WOUND CARE	101,160		101,160	0	0	76.03
76.04	03953	ALLERGY 123	0		0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,741,270		6,741,270	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	253,130		253,130	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,104,172		1,104,172	0	0	88.02
91.00	09100	EMERGENCY	4,295,083		4,295,083	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	687,635		687,635		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	855,068		855,068	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,199,673		1,199,673		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,028,852	0	31,028,852	0	0	200.00
201.00		Less Observation Beds	687,635		687,635		0	201.00
202.00		Total (see instructions)	30,341,217	0	30,341,217	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,197,279		2,197,279			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,521	1,760,955	1,794,476	0.490877	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	29,888	1,063,843	1,093,731	0.332755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,368	9,482,757	9,770,125	0.208686	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	22,444	1,166,660	1,189,104	0.180571	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,955	454,642	457,597	0.394878	0.000000	56.00
58.00	05800	MRI	44,041	1,904,913	1,948,954	0.103494	0.000000	58.00
60.00	06000	LABORATORY	521,307	9,823,612	10,344,919	0.287465	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,886	144,249	159,135	1.087611	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	47,168	562,837	610,005	0.061298	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	409,848	3,742,955	4,152,803	0.350351	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,077	1,297,882	1,679,959	0.308668	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,235	384,245	412,480	0.397394	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	293,102	1,311,303	1,604,405	0.587266	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	216,117	521,473	737,590	0.855330	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	282,588	942,491	1,225,079	1.069837	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,211,455	1,211,455	0.472244	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	587	587	45.231687	0.000000	76.02
76.03	03951	WOUND CARE	0	713,570	713,570	0.141766	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0.000000	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,024,882	5,024,882			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	234,963	234,963			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,013,434	1,013,434			88.02
91.00	09100	EMERGENCY	18,501	3,130,176	3,148,677	1.364091	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	787,956	787,956	0.872682	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,790	2,781,427	2,787,217	0.306782	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,790,777	2,790,777			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,837,115	52,254,044	57,091,159			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,837,115	52,254,044	57,091,159			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	76.02
76.03	03951	WOUND CARE	0.000000	76.03
76.04	03953	ALLERGY 123	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,106,778		3,106,778	0	3,106,778	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	880,867		880,867	0	880,867	50.00
53.00	05300	ANESTHESIOLOGY	363,945		363,945	0	363,945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,038,893		2,038,893	0	2,038,893	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	214,718		214,718	0	214,718	54.01
56.00	05600	RADIOISOTOPE	180,695		180,695	0	180,695	56.00
58.00	05800	MRI	201,706		201,706	0	201,706	58.00
60.00	06000	LABORATORY	2,973,802		2,973,802	0	2,973,802	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	173,077		173,077	0	173,077	62.00
64.00	06400	INTRAVENOUS THERAPY	37,392		37,392	0	37,392	64.00
66.00	06600	PHYSICAL THERAPY	1,454,938	0	1,454,938	0	1,454,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,550	0	518,550	0	518,550	67.00
68.00	06800	SPEECH PATHOLOGY	163,917	0	163,917	0	163,917	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	942,212		942,212	0	942,212	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	630,883		630,883	0	630,883	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,635		1,310,635	0	1,310,635	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	572,102		572,102	0	572,102	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0		0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	26,551		26,551	0	26,551	76.02
76.03	03951	WOUND CARE	101,160		101,160	0	101,160	76.03
76.04	03953	ALLERGY 123	0		0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,741,270		6,741,270	0	6,741,270	88.00
88.01	08801	RURAL HEALTH CLINIC II	253,130		253,130	0	253,130	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,104,172		1,104,172	0	1,104,172	88.02
91.00	09100	EMERGENCY	4,295,083		4,295,083	0	4,295,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	687,635		687,635		687,635	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	855,068		855,068	0	855,068	95.00
101.00	10100	HOME HEALTH AGENCY	1,199,673		1,199,673		1,199,673	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,028,852	0	31,028,852	0	31,028,852	200.00
201.00		Less Observation Beds	687,635		687,635		687,635	201.00
202.00		Total (see instructions)	30,341,217	0	30,341,217	0	30,341,217	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,197,279		2,197,279			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,521	1,760,955	1,794,476	0.490877	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	29,888	1,063,843	1,093,731	0.332755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,368	9,482,757	9,770,125	0.208686	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	22,444	1,166,660	1,189,104	0.180571	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,955	454,642	457,597	0.394878	0.000000	56.00
58.00	05800	MRI	44,041	1,904,913	1,948,954	0.103494	0.000000	58.00
60.00	06000	LABORATORY	521,307	9,823,612	10,344,919	0.287465	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,886	144,249	159,135	1.087611	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	47,168	562,837	610,005	0.061298	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	409,848	3,742,955	4,152,803	0.350351	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,077	1,297,882	1,679,959	0.308668	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,235	384,245	412,480	0.397394	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	293,102	1,311,303	1,604,405	0.587266	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	216,117	521,473	737,590	0.855330	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	282,588	942,491	1,225,079	1.069837	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,211,455	1,211,455	0.472244	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	587	587	45.231687	0.000000	76.02
76.03	03951	WOUND CARE	0	713,570	713,570	0.141766	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0.000000	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,024,882	5,024,882	1.341578	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	234,963	234,963	1.077319	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,013,434	1,013,434	1.089535	0.000000	88.02
91.00	09100	EMERGENCY	18,501	3,130,176	3,148,677	1.364091	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	787,956	787,956	0.872682	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,790	2,781,427	2,787,217	0.306782	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,790,777	2,790,777			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,837,115	52,254,044	57,091,159			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,837,115	52,254,044	57,091,159			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 10:49 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
76.03	03951	WOUND CARE	0.000000		76.03
76.04	03953	ALLERGY 123	0.000000		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	180,081	1,794,476	0.100353	30,330	3,044	50.00
53.00	05300	ANESTHESIOLOGY	1,326	1,093,731	0.001212	26,426	32	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	347,688	9,770,125	0.035587	78,189	2,783	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,071	1,189,104	0.005106	8,666	44	54.01
56.00	05600	RADIOISOTOPE	7,451	457,597	0.016283	0	0	56.00
58.00	05800	MRI	4,337	1,948,954	0.002225	16,381	36	58.00
60.00	06000	LABORATORY	122,473	10,344,919	0.011839	186,566	2,209	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,370	159,135	0.021177	8,606	182	62.00
64.00	06400	INTRAVENOUS THERAPY	1,188	610,005	0.001948	7,656	15	64.00
66.00	06600	PHYSICAL THERAPY	95,472	4,152,803	0.022990	70,279	1,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,237	1,679,959	0.006094	58,881	359	67.00
68.00	06800	SPEECH PATHOLOGY	3,852	412,480	0.009339	3,497	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	57,760	1,604,405	0.036001	100,109	3,604	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,444	737,590	0.016871	88,245	1,489	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,630	1,225,079	0.041328	131,138	5,420	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,614	1,211,455	0.009587	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0.000000	0	0	76.01
76.02	03950	DIABETIC EDUCATION	324	587	0.551959	0	0	76.02
76.03	03951	WOUND CARE	1,877	713,570	0.002630	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0.000000	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	144,836	5,024,882	0.028824	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,507	234,963	0.019182	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,277	1,013,434	0.013101	0	0	88.02
91.00	09100	EMERGENCY	114,396	3,148,677	0.036331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	61,060	787,956	0.077492	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,256,271	49,315,886		814,969	20,866	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	349,459	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	349,459	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,794,476	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	349,459	0	1,093,731	0.319511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,770,125	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	1,189,104	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	457,597	0.000000	56.00
58.00	05800	MRI	0	0	0	1,948,954	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	10,344,919	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	159,135	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	610,005	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,152,803	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,679,959	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	412,480	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,604,405	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	737,590	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,225,079	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,211,455	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	587	0.000000	76.02
76.03	03951	WOUND CARE	0	0	0	713,570	0.000000	76.03
76.04	03953	ALLERGY 123	0	0	0	0	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,024,882	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	234,963	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,013,434	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	3,148,677	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	787,956	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	349,459	0	49,315,886		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	30,330	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	26,426	8,443	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	78,189	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	8,666	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	16,381	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	186,566	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	8,606	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	7,656	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	70,279	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	58,881	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,497	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	100,109	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	88,245	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	131,138	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		814,969	8,443	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.490877	0	486,890	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.332755	0	305,267	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208686	0	3,060,530	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.180571	0	363,321	0	0	54.01
56.00	05600	RADIOISOTOPE	0.394878	0	155,576	0	0	56.00
58.00	05800	MRI	0.103494	0	473,603	0	0	58.00
60.00	06000	LABORATORY	0.287465	0	3,151,060	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.087611	0	54,107	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061298	0	195,326	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.350351	0	1,251,587	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.308668	0	127,770	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.397394	0	44,134	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.587266	0	498,561	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.855330	0	145,788	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.069837	0	686,813	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.472244	0	895,142	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	45.231687	0	219	0	0	76.02
76.03	03951	WOUND CARE	0.141766	0	350,007	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	1.364091	0	724,022	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.872682	0	255,353	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.306782		0			95.00
200.00		Subtotal (see instructions)		0	13,225,076	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,225,076	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	239,003	0	50.00
53.00	05300	ANESTHESIOLOGY	101,579	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	638,690	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	65,605	0	54.01
56.00	05600	RADIOISOTOPE	61,434	0	56.00
58.00	05800	MRI	49,015	0	58.00
60.00	06000	LABORATORY	905,819	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,847	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,973	0	64.00
66.00	06600	PHYSICAL THERAPY	438,495	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,439	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,539	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	292,788	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,697	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734,778	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,725	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	76.01
76.02	03950	DIABETIC EDUCATION	9,906	0	76.02
76.03	03951	WOUND CARE	49,619	0	76.03
76.04	03953	ALLERGY 123	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	987,632	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	222,842	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,472,425	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,472,425	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	850	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.	17	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	582	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	68	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)	204	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	40	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)	118	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	250	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)	66	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)	199	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)	13	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,106,778	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)	8,348	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)	24,627	25.00
26.00	Total swing-bed cost (see instructions)	778,138	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,328,640	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	992,177	28.00
29.00	Private room charges (excluding swing-bed charges)	49,015	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	943,162	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.347001	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,883.24	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,620.55	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	1,262.69	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	2,963.53	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	50,380	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,278,260	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,680.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	670,078	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	38,526	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	708,604	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	425,471	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,134,075	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	176,900	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	533,382	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	710,282	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)	251	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,739.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	687,635	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	275,872	3,106,778	0.088797	687,635	61,060	90.00
91.00	Nursing Program cost	0	3,106,778	0.000000	687,635	0	91.00
92.00	Allied health cost	0	3,106,778	0.000000	687,635	0	92.00
93.00	All other Medical Education	0	3,106,778	0.000000	687,635	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		588,486		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.490877	30,330	14,888	50.00
53.00	05300	ANESTHESIOLOGY	0.332755	26,426	8,793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208686	78,189	16,317	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.180571	8,666	1,565	54.01
56.00	05600	RADIOISOTOPE	0.394878	0	0	56.00
58.00	05800	MRI	0.103494	16,381	1,695	58.00
60.00	06000	LABORATORY	0.287465	186,566	53,631	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.087611	8,606	9,360	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061298	7,656	469	64.00
66.00	06600	PHYSICAL THERAPY	0.350351	70,279	24,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.308668	58,881	18,175	67.00
68.00	06800	SPEECH PATHOLOGY	0.397394	3,497	1,390	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.587266	100,109	58,791	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.855330	88,245	75,479	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.069837	131,138	140,296	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.472244	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	76.01
76.02	03950	DIABETIC EDUCATION	45.231687	0	0	76.02
76.03	03951	WOUND CARE	0.141766	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	1.364091	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.872682	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		814,969	425,471	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)		814,969		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.490877	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.332755	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208686	3,979	830	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.180571	91	16	54.01
56.00	05600	RADIOISOTOPE	0.394878	0	0	56.00
58.00	05800	MRI	0.103494	0	0	58.00
60.00	06000	LABORATORY	0.287465	41,180	11,838	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.087611	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061298	2,974	182	64.00
66.00	06600	PHYSICAL THERAPY	0.350351	155,927	54,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.308668	148,309	45,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.397394	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.587266	13,833	8,124	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.855330	21,220	18,150	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.069837	31,407	33,600	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.472244	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	76.01
76.02	03950	DIABETIC EDUCATION	45.231687	0	0	76.02
76.03	03951	WOUND CARE	0.141766	0	0	76.03
76.04	03953	ALLERGY 123	0.000000	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	1.364091	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.872682	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		418,920	173,147	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)		418,920		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,472,425	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,472,425	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,527,149	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)	25,750	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,989,265	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)	3,512,134	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)	3,512,134	30.00
31.00	Primary payer payments	169	31.00
32.00	Subtotal (line 30 minus line 31)	3,511,965	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)	88,921	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	57,799	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	88,921	36.00
37.00	Subtotal (see instructions)	3,569,764	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)	3,569,764	40.00
40.01	Sequestration adjustment (see instructions)	71,395	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	3,226,594	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)	271,775	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/26/2024 10:49 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		779,629		3,226,594	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	06/22/2023	65,100	06/22/2023	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)		65,100		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)		844,729		3,226,594	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		187,758		271,775	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,032,487		3,498,369	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		654,517		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/22/2023	39,600		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)		39,600		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)		694,117		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		177,949		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		872,066		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	717,385	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	174,878	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	265	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	892,263	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	892,263	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	892,263	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,400	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	889,863	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	889,863	0	19.00
19.01	Sequestration adjustment (see instructions)	17,797	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	694,117	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	177,949	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/26/2024 10:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,134,075	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,134,075	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,134,075	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,134,075	19.00
20.00	Deductibles (exclude professional component)	88,896	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,045,179	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,045,179	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,891	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,379	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,891	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,053,558	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,053,558	30.00
30.01	Sequestration adjustment (see instructions)	21,071	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	844,729	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	187,758	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/26/2024 10:49 am

		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	16,346,324	0	0	0	1.00
2.00	Temporary investments	674,250	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,029,588	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	607,698	0	0	0	7.00
8.00	Prepaid expenses	201,240	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,859,100	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,415,223	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,415,223	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,388,194	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,388,194	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,662,517	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,381,067	0	0	0	37.00
38.00	Salaries, wages, and fees payable	331,019	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	958,952	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	1,748,061	0	0	0	43.00
44.00	Other current liabilities	1,577,464	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,996,563	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,636,577	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,691,676	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,328,253	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,324,816	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,337,701				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)	27,337,701	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,662,517	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/26/2024 10:49 am

		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		26,748,595		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		589,106				2.00
3.00	Total (sum of line 1 and line 2)		27,337,701		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,337,701		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)		27,337,701		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/26/2024 10:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,814,485		2,814,485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	746,586		746,586	5.00
6.00	Swing bed - NF	7,176		7,176	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,568,247		3,568,247	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,568,247		3,568,247	17.00
18.00	Ancillary services	2,619,815	38,227,762	40,847,577	18.00
19.00	Outpatient services	21,314	5,908,738	5,930,052	19.00
20.00	RURAL HEALTH CLINIC	0	5,024,882	5,024,882	20.00
20.01	RURAL HEALTH CLINIC II	0	234,963	234,963	20.01
20.02	RURAL HEALTH CLINIC III	0	1,013,434	1,013,434	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,790,777	2,790,777	22.00
23.00	AMBULANCE SERVICES	5,790	2,754,071	2,759,861	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,215,166	55,954,627	62,169,793	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,965,497		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	EMPLOYEE PHYSICALS -DEDUCTION	35,300			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)		35,300		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,930,197		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/26/2024 10:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,169,793	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,745,340	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,424,453	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,930,197	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,505,744	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	442,199	6.00
7.00	Income from investments	401,009	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	981,008	23.00
24.00	OTHER REVENUE	1,258,196	24.00
24.50	COVID-19 PHE Funding	12,438	24.50
25.00	Total other income (sum of lines 6-24)	3,094,850	25.00
26.00	Total (line 5 plus line 25)	589,106	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	589,106	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H | Date/Time Prepared: 2/26/2024 10:49 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	150,541	11,335	53,701	0	89,794	305,371	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	498,044	37,501	0	0	0	535,545	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	5,461	411	0	0	0	5,872	10.00
11.00	Home Health Aide	41,648	3,136	0	0	0	44,784	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	695,694	52,383	53,701	0	89,794	891,572	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	305,371	0	305,371			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	535,545	0	535,545			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	5,872	0	5,872			10.00
11.00	Home Health Aide	0	44,784	0	44,784			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	891,572	0	891,572			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1313 HHA CCN: 14-7202

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

Worksheet H-1 Part I Date/Time Prepared: 2/26/2024 10:49 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	305,371	0	0	0	0	305,371	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	535,545	0	0	0	0	535,545	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	5,872	0	0	0	0	5,872	10.00
11.00	Home Health Aide	44,784	0	0	0	0	44,784	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	891,572	0	0	0	0	891,572	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	305,371			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	278,983	814,528		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	3,059	8,931		10.00
11.00	Home Health Aide	23,329	68,113		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		891,572		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-1 Part II | Date/Time Prepared: 2/26/2024 10:49 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-305,371	586,201	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	535,545	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	5,872	10.00
11.00	Home Health Aide	0	0	0	0	0	44,784	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-305,371	586,201	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		305,371	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.520932	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUI	MVBLE EQUIP	
		0	1.00	1.01	1.02	1.03	2.00	
1.00	Administrative and General	0	0	3,777	0	0	7,747	1.00
2.00	Skilled Nursing Care	814,528	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	8,931	0	0	0	0	0	6.00
7.00	Home Health Aide	68,113	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	891,572	0	3,777	0	0	7,747	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
		4.00	4A	5.01	5A.01	5.02	6.00	
1.00	Administrative and General	140,691	152,215	14,708	166,923	0	17,789	1.00
2.00	Skilled Nursing Care	0	814,528	78,705	893,233	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	8,931	863	9,794	0	0	6.00
7.00	Home Health Aide	0	68,113	6,581	74,694	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	140,691	1,043,787	100,857	1,144,644	0	17,789	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000		0.000000			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BU	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.01	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	0	0	0	0	145	16,519	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	145	16,519	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.01	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	20,576	0	221,952	0	221,952		1.00
2.00	Skilled Nursing Care	0	0	893,233	0	893,233	202,773	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	9,794	0	9,794	2,223	6.00
7.00	Home Health Aide	0	0	74,694	0	74,694	16,956	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	20,576	0	1,199,673	0	1,199,673	221,952	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.227010	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,096,006	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	12,017	6.00
7.00	Home Health Aide	91,650	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,199,673	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part II | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUI (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
		1.00	1.01	1.02	1.03	2.00	4.00	
1.00	Administrative and General	0	1,594	0	0	8,363	695,694	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,594	0	0	8,363	695,694	20.00
21.00	Total cost to be allocated	0	3,777	0	0	7,747	140,691	21.00
22.00	Unit cost multiplier	0.000000	2.369511	0.000000	0.000000	0.926342	0.202231	22.00

	Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	6.01	
1.00	Administrative and General	0	152,215	-166,923	0	1,594	0	1.00
2.00	Skilled Nursing Care	0	814,528	-893,233	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	8,931	-9,794	0	0	0	6.00
7.00	Home Health Aide	0	68,113	-74,694	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)		1,043,787		0	1,594	0	20.00
21.00	Total cost to be allocated		100,857		0	17,789	0	21.00
22.00	Unit cost multiplier		0.096626		0.000000	11.159975	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part II | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BU (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	
		7.00	7.01	7.02	8.00	9.00	9.01	
1.00	Administrative and General	0	0	0	80	1,594	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	80	1,594	0	20.00
21.00	Total cost to be allocated	0	0	0	145	16,519	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	1.812500	10.363237	0.000000	22.00

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	2,790,777	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,790,777	20.00
21.00	Total cost to be allocated	0	0	0	0	0	20,576	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.007373	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313
HHA CCN: 14-7202

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

Worksheet H-2
Part II
Date/Time Prepared:
2/26/2024 10:49 am

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	Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		19.00		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
19.50	Telemedicine	0		19.50
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2024 10:49 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,096,006		1,096,006	4,718	232.30	1.00
2.00	Physical Therapy	3.00	0	254,922	254,922	2,010	126.83	2.00
3.00	Occupational Therapy	4.00	0	110,732	110,732	991	111.74	3.00
4.00	Speech Pathology	5.00	0	16,238	16,238	113	143.70	4.00
5.00	Medical Social Services	6.00	12,017		12,017	54	222.54	5.00
6.00	Home Health Aide	7.00	91,650		91,650	338	271.15	6.00
7.00	Total (sum of lines 1-6)		1,199,673	381,892	1,581,565	8,224		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	0	76			8.00
8.01	Skilled Nursing Care		44100	0	68			8.01
8.02	Skilled Nursing Care		99914	0	2,435			8.02
9.00	Physical Therapy		37900	0	17			9.00
9.01	Physical Therapy		44100	0	0			9.01
9.02	Physical Therapy		99914	0	1,158			9.02
10.00	Occupational Therapy		37900	0	15			10.00
10.01	Occupational Therapy		44100	0	0			10.01
10.02	Occupational Therapy		99914	0	499			10.02
11.00	Speech Pathology		37900	0	0			11.00
11.01	Speech Pathology		44100	0	0			11.01
11.02	Speech Pathology		99914	0	47			11.02
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		44100	0	0			12.01
12.02	Medical Social Services		99914	0	2			12.02
13.00	Home Health Aide		37900	0	0			13.00
13.01	Home Health Aide		44100	0	0			13.01
13.02	Home Health Aide		99914	0	229			13.02
14.00	Total (sum of lines 8-13)			0	4,546			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	27,495	27,495	32,145	0.855343	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,579		0	599,102		1.00
2.00	Physical Therapy	0	1,175		0	149,025		2.00
3.00	Occupational Therapy	0	514		0	57,434		3.00
4.00	Speech Pathology	0	47		0	6,754		4.00
5.00	Medical Social Services	0	2		0	445		5.00
6.00	Home Health Aide	0	229		0	62,093		6.00
7.00	Total (sum of lines 1-6)	0	4,546		0	874,853		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 2/26/2024 10:49 am

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	8,204	0	0	7,017	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	599,102		1.00
2.00	Physical Therapy	149,025		2.00
3.00	Occupational Therapy	57,434		3.00
4.00	Speech Pathology	6,754		4.00
5.00	Medical Social Services	445		5.00
6.00	Home Health Aide	62,093		6.00
7.00	Total (sum of lines 1-6)	874,853		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313
HHA CCN: 14-7202

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

Worksheet H-3
Part II
Date/Time Prepared:
2/26/2024 10:49 am

Home Health Agency I

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.350351	727,620	254,922	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.308668	358,742	110,732	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.397394	40,861	16,238	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.855330	32,145	27,495	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.069837	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	607,851	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	153,829	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,548	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	67,833	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	834,061	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	834,061	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	834,061	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	834,061	29.00
30.00	OTHER ADJUSTMENT	0	-1	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	834,060	31.00
31.01	Sequestration adjustment (see instructions)	0	16,681	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	817,379	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-5 | Date/Time Prepared: 2/26/2024 10:49 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		817,379	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		817,379	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		817,379	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,857,041	0	1,857,041	-47,875	1,809,166	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	513,556	0	513,556	0	513,556	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	485,136	0	485,136	0	485,136	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)	2,855,733	0	2,855,733	-47,875	2,807,858	10.00
11.00	Physician Services Under Agreement	0	778,454	778,454	0	778,454	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	12,530	12,530	0	12,530	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	790,984	790,984	0	790,984	14.00
15.00	Medical Supplies	0	124,134	124,134	0	124,134	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	120,900	120,900	0	120,900	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	245,034	245,034	0	245,034	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,855,733	1,036,018	3,891,751	-47,875	3,843,876	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	13,166	0	13,166	0	13,166	25.01
25.02	Chronic Care Management	28,340	0	28,340	0	28,340	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)	41,506	0	41,506	0	41,506	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,257	9,257	0	9,257	29.00
30.00	Administrative Costs	410,124	670,503	1,080,627	0	1,080,627	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	410,124	679,760	1,089,884	0	1,089,884	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,307,363	1,715,778	5,023,141	-47,875	4,975,266	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,809,166		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	513,556		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	485,136		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	2,807,858		10.00
11.00	Physician Services Under Agreement	0	778,454		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	12,530		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	790,984		14.00
15.00	Medical Supplies	0	124,134		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	120,900		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	245,034		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,843,876		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	13,166		25.01
25.02	Chronic Care Management	0	28,340		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	41,506		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,257		29.00
30.00	Administrative Costs	0	1,080,627		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,089,884		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,975,266		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

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	44,412	0	44,412	0	44,412	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	25,882	0	25,882	0	25,882	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	17,865	0	17,865	0	17,865	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)	88,159	0	88,159	0	88,159	10.00
11.00	Physician Services Under Agreement	0	4,002	4,002	0	4,002	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	5,532	5,532	0	5,532	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,534	9,534	0	9,534	14.00
15.00	Medical Supplies	0	4,462	4,462	0	4,462	15.00
16.00	Transportation (Health Care Staff)	0	5,282	5,282	0	5,282	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	3,722	3,722	0	3,722	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,466	13,466	0	13,466	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	88,159	23,000	111,159	0	111,159	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,965	2,965	0	2,965	29.00
30.00	Administrative Costs	40,964	46,303	87,267	0	87,267	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,964	49,268	90,232	0	90,232	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	129,123	72,268	201,391	0	201,391	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

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	44,412		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	25,882		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	17,865		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	88,159		10.00
11.00	Physician Services Under Agreement	0	4,002		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	5,532		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,534		14.00
15.00	Medical Supplies	0	4,462		15.00
16.00	Transportation (Health Care Staff)	0	5,282		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	3,722		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,466		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	111,159		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,965		29.00
30.00	Administrative Costs	0	87,267		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,232		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	201,391		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-8592 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

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	282,430	0	282,430	0	282,430	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	126,322	0	126,322	0	126,322	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	158,436	0	158,436	0	158,436	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)	567,188	0	567,188	0	567,188	10.00
11.00	Physician Services Under Agreement	0	7,545	7,545	0	7,545	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	5,943	5,943	0	5,943	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,488	13,488	0	13,488	14.00
15.00	Medical Supplies	0	72,726	72,726	0	72,726	15.00
16.00	Transportation (Health Care Staff)	0	514	514	0	514	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	8,328	8,328	0	8,328	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	81,568	81,568	0	81,568	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	567,188	95,056	662,244	0	662,244	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	1,231	0	1,231	0	1,231	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)	1,231	0	1,231	0	1,231	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,731	7,731	0	7,731	29.00
30.00	Administrative Costs	67,999	88,559	156,558	0	156,558	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,999	96,290	164,289	0	164,289	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	636,418	191,346	827,764	0	827,764	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-8592 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 10:49 am

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	282,430		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	126,322		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	158,436		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	567,188		10.00
11.00	Physician Services Under Agreement	0	7,545		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	5,943		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,488		14.00
15.00	Medical Supplies	0	72,726		15.00
16.00	Transportation (Health Care Staff)	0	514		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	8,328		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	81,568		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	662,244		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	1,231		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	1,231		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,731		29.00
30.00	Administrative Costs	-300	156,258		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-300	163,989		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-300	827,464		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/26/2024 10:49 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Greater of col. 2 or col. 4	Cost	
		1.00	2.00	3.00	4.00	5.00		
	VISITS AND PRODUCTIVITY							
	Positions							
1.00	Physician	3.26	10,351	1	3			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	3.38	7,124	1	3			3.00
4.00	Subtotal (sum of lines 1 through 3)	6.64	17,475		6	17,475		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)	6.64	17,475			17,475		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)					3,843,876		10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					41,506		11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,885,382		12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.989317		13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,089,884		14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,766,004		15.00
16.00	Total overhead (sum of lines 14 and 15)					2,855,888		16.00
17.00	Allowable GME overhead (see instructions)					0		17.00
18.00	Enter the amount from line 16					2,855,888		18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,825,379		19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,669,255		20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/26/2024 10:49 am

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	0.16	472	1	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.14	485	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.30	957		0	957	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)	0.30	957			957	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)					111,159	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)					111,159	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)					90,232	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					51,739	15.00
16.00	Total overhead (sum of lines 14 and 15)					141,971	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					141,971	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					141,971	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					253,130	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-8592 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/26/2024 10:49 am

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	0.80	2,306	1	1		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.60	1,740	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.40	4,046		2	4,046	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)	1.40	4,046			4,046	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)					662,244	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,231	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					663,475	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998145	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					163,989	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					276,708	15.00
16.00	Total overhead (sum of lines 14 and 15)					440,697	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					440,697	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					439,880	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,102,124	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/26/2024 10:49 am
	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)		6,669,255	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		144,909	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		6,524,346	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,475	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)		17,475	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		373.35	7.00
		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	388.19	366.71	8.00
9.00	Rate for Program covered visits (see instructions)	373.35	366.71	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	989	2,990	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	369,243	1,096,463	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,465,706	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,032,366	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		64,691	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		91,846	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,022,626	16.04
16.05	Total program cost (see instructions)	0	1,114,472	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		95,577	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		174,318	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,114,472	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		26,100	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,140,572	22.00
23.00	Allowable bad debts (see instructions)		42,773	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		27,802	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,168,374	26.00
26.01	Sequestration adjustment (see instructions)		23,367	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,155,541	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-10,534	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/26/2024 10:49 am
	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)			253,130	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			10,859	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			242,271	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			957	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)			957	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			253.16	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	345.47	358.61		8.00
9.00	Rate for Program covered visits (see instructions)	253.16	253.16		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	27	129		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	6,835	32,658		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	39,493		16.00
16.01	Total program charges (see instructions)(from contractor's records)		41,764		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,870		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,714		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.)		25,336		16.04
16.05	Total program cost (see instructions)	0	28,050		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,109		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,757		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		28,050		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,909		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		35,959		22.00
23.00	Allowable bad debts (see instructions)		2,573		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,672		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)		37,631		26.00
26.01	Sequestration adjustment (see instructions)		753		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		40,065		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-3,187		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-8592	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/26/2024 10:49 am
	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)			1,102,124	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			57,534	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,044,590	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,046	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)			4,046	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			258.18	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	285.66	275.79		8.00
9.00	Rate for Program covered visits (see instructions)	258.18	258.18		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	73	209		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	18,847	53,960		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	72,807		16.00
16.01	Total program charges (see instructions)(from contractor's records)		76,396		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,994		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,290		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.)		39,766		16.04
16.05	Total program cost (see instructions)	0	54,056		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,809		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,519		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		54,056		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,624		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		64,680		22.00
23.00	Allowable bad debts (see instructions)		1,697		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,103		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)		65,783		26.00
26.01	Sequestration adjustment (see instructions)		1,316		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		58,899		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)		5,568		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 10:49 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,807,858	2,807,858	2,807,858	2,807,858	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000854	0.001755	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,398	4,928	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	65,964	10,230	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	68,362	15,158	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,843,876	3,843,876	3,843,876	3,843,876	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,825,379	2,825,379	2,825,379	2,825,379	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.017785	0.003943	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	50,249	11,140	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	118,611	26,298	0	0	10.00
11.00	Total number of injections/infusions (from your records)	259	532	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	457.96	49.43	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	19	352	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)	8,701	17,399	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)		144,909	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)		26,100	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 10:49 am

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)	88,159	88,159	88,159	88,159	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000666	0.001249	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	59	110	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,023	577	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,082	687	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	111,159	111,159	111,159	111,159	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	141,971	141,971	141,971	141,971	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.036722	0.006180	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,213	877	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9,295	1,564	0	0	10.00
11.00	Total number of injections/infusions (from your records)	16	30	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	580.94	52.13	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	18	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)	6,971	938	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)		10,859	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)		7,909	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-8592 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 10:49 am

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)	567,188	567,188	567,188	567,188	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001263	0.002832	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	716	1,606	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	27,915	4,334	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	28,631	5,940	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	662,244	662,244	662,244	662,244	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	439,880	439,880	439,880	439,880	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.043233	0.008970	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	19,017	3,946	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	47,648	9,886	0	0	10.00
11.00	Total number of injections/infusions (from your records)	70	157	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	680.69	62.97	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	39	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)	8,168	2,456	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)		57,534	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)		10,624	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/26/2024 10:49 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,155,541	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)		1,155,541	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,534	6.02
7.00	Total Medicare program liability (see instructions)		1,145,007	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/26/2024 10:49 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		40,065	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)		40,065	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,187	6.02
7.00	Total Medicare program liability (see instructions)		36,878	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-8592	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/26/2024 10:49 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		58,899	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)		58,899	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		5,568	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		64,467	7.00

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