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: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 8:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 8:49 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 ADAMS MEMORIAL HOSPITAL (15-1330) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	448,783	-662,732	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	208,282	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	MONROE FAMILY MEDICINE I	0		250,977		0	10.00
10.01	WOODCREST II	0		72,751		0	10.01
10.02	STAT CARE III	0		17,358		0	10.02
10.03	BERNE FAMILY MEDICINE IV	0		147,531		0	10.03
10.04	HIGH STREET V	0		14,822		0	10.04
200.00	TOTAL	0	657,065	-159,293	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1100 MERCER AVENEUE	PO Box:			1.00
2.00	City: DECATUR	State: IN	Zip Code: 46733	County: ADAMS	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	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	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	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MONROE FAMILY MEDICINE	158526	99915		10/25/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	DECATUR FAMILY MEDICINE-WOODCREST	158536	99915		12/26/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	STAT CARE & PRIMARY CARE CLINIC	158537	99915		12/18/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	BERNE FAMILY MEDICINE	158559	99915		07/01/2020	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	HIGH STREET FAMILY MEDICINE	158555	99915		01/24/2020	N	O	N	15.04
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)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		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			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:49 am

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

		1.00 In-State Medicaid paid days	2.00 In-State Medicaid eligible unpaid days	3.00 Out-of State Medicaid paid days	4.00 Out-of State Medicaid eligible unpaid	5.00 Medicaid HMO days	6.00 Other Medicaid days	
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

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

		1.00 Beginning:	2.00 Ending:	
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

		1.00 Y/N	2.00 Y/N	
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

		1.00 V	2.00 XVIII	3.00 XIX	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:49 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:49 am

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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:49 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:49 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	540,150	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	N	123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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		1.00	2.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H060	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: ADAMS HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 MERCER AVE	PO Box:		142.00
143.00	City: DECATUR	State: IN	Zip Code: 46733	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:49 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 8:49 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	04/17/2024	Y	04/17/2024	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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 8:49 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		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.	ANDREW	MCCABE	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.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.	CPA		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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 8:49 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	21	7,665	41,904.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	41,904.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	10,056.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	51,960.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	0	2,730		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	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	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	88.00				0	26.00
26.01	WOODCREST	88.01				0	26.01
26.02	STAT CARE	88.02				0	26.02
26.03	BERNE FAMILY MEDICINE	88.03				0	26.03
26.04	HIGH STREET	88.04				0	26.04
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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:49 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)	840	0	1,746			1.00
2.00	HMO and other (see instructions)	577	133				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	458	0	885			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	141			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,298	0	2,772			7.00
8.00	INTENSIVE CARE UNIT	175	131	779			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		107	293			13.00
14.00	Total (see instructions)	1,473	238	3,844	0.00	562.41	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	4,706	0	13,852	0.00	18.85	26.00
26.01	WOODCREST	1,327	0	9,095	0.00	13.61	26.01
26.02	STAT CARE	692	0	11,111	0.00	15.27	26.02
26.03	BERNE FAMILY MEDICINE	1,191	0	8,539	0.00	13.97	26.03
26.04	HIGH STREET	1,900	0	7,764	0.00	8.88	26.04
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	632.99	27.00
28.00	Observation Bed Days		0	1,882			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			93			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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:49 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	316	0	931	1.00
2.00	HMO and other (see instructions)			198	191		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	316	0	931	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						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	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	0.00					26.00
26.01	WOODCREST	0.00					26.01
26.02	STAT CARE	0.00					26.02
26.03	BERNE FAMILY MEDICINE	0.00					26.03
26.04	HIGH STREET	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:49 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			205 TOWER DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MONROE		IN	46772	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.)			Y	1	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	20:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N	0	13.01
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:49 am
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:49 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1300 MERCER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N	0	13.01
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8536	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:49 am
		RHC II	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:49 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1100 MERCER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	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	09:00	17:00	07:30	20:30	07:30	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8537	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:49 am
		RHC III	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				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	20:30	07:30	20:30	07:30	20:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	20:30	09:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:49 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1521 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BERNE		IN	46711	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8559	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:49 am
		RHC IV	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:30	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:49 am

RHC V | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			955 HIGH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8555	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:49 am
		RHC V	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:49 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)	0.542581	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,893,149	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	24,564,084	6.00
7.00	Medicaid cost (line 1 times line 6)	13,328,005	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	6,434,856	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,434,856	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)	31,359	20,986	52,345	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	17,015	20,986	38,001	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)	17,015	20,986	38,001	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)	9,718,753	26.00
27.00	Medicare reimbursable bad debts (see instructions)	123,983	27.00
27.01	Medicare allowable bad debts (see instructions)	190,744	27.01
28.00	Non-Medicare bad debt amount (see instructions)	9,528,009	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	5,236,478	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	5,274,479	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,709,335	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:49 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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT		2,057,404	2,057,404	83,962	2,141,366	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133,939	139,591	273,530	0	273,530	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,660,492	9,776,980	13,437,472	-99,494	13,337,978	5.00
7.00	00700	OPERATION OF PLANT	0	2,328,778	2,328,778	1,178	2,329,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,205	195,523	285,728	0	285,728	8.00
9.00	00900	HOUSEKEEPING	688,332	288,522	976,854	3,951	980,805	9.00
10.00	01000	DIETARY	673,838	799,082	1,472,920	0	1,472,920	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	937,273	225,202	1,162,475	0	1,162,475	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	916,554	679,309	1,595,863	0	1,595,863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,765	213,051	575,816	0	575,816	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,828,053	3,026,824	6,854,877	-24,611	6,830,266	30.00
31.00	03100	INTENSIVE CARE UNIT	792,995	846,019	1,639,014	0	1,639,014	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	7,533	7,533	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,554,704	3,473,215	6,027,919	0	6,027,919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,078	17,078	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,142	1,898,528	3,407,670	0	3,407,670	54.00
60.00	06000	LABORATORY	1,625,859	3,156,636	4,782,495	7,070	4,789,565	60.00
65.00	06500	RESPIRATORY THERAPY	582,666	190,470	773,136	0	773,136	65.00
66.00	06600	PHYSICAL THERAPY	2,072,819	642,745	2,715,564	0	2,715,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	571,506	129,131	700,637	0	700,637	67.00
68.00	06800	SPEECH PATHOLOGY	290,919	48,463	339,382	0	339,382	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,226,126	1,226,126	0	1,226,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,558,763	1,558,763	0	1,558,763	73.00
76.00	03020	OP PSYCH	1,007,007	250,159	1,257,166	0	1,257,166	76.00
76.01	03030	WOUND CARE	365,010	111,739	476,749	0	476,749	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	1,903,251	725,213	2,628,464	0	2,628,464	88.00
88.01	08801	WOODCREST	1,239,123	569,079	1,808,202	0	1,808,202	88.01
88.02	08802	STAT CARE	1,147,285	471,603	1,618,888	0	1,618,888	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,247,672	748,534	1,996,206	0	1,996,206	88.03
88.04	08804	HIGH STREET	949,239	471,684	1,420,923	0	1,420,923	88.04
90.00	09000	CLINIC	3,169,456	1,598,888	4,768,344	-58,934	4,709,410	90.00
90.01	09001	CLINIC - AMO	2,232,528	430,597	2,663,125	21,110	2,684,235	90.01
90.02	09002	CLINIC - AMH NEURO	869,971	133,346	1,003,317	24,324	1,027,641	90.02
90.03	09003	GENERAL SURGERY OFFICE	1,478,983	741,769	2,220,752	25,625	2,246,377	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,010,376	1,168,552	4,178,928	0	4,178,928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,476,252	885,286	2,361,538	0	2,361,538	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,388,214	41,206,811	82,595,025	8,792	82,603,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	740,270	461,410	1,201,680	-24,324	1,177,356	194.01
194.02	07952	OTHER MOBS	0	0	0	15,532	15,532	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	322,219	322,219	0	322,219	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	42,128,484	41,990,440	84,118,924	0	84,118,924	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-108,306	2,033,060		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	273,530		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,254,652	14,592,630		5.00
7.00	00700	OPERATION OF PLANT	698,106	3,028,062		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	285,728		8.00
9.00	00900	HOUSEKEEPING	0	980,805		9.00
10.00	01000	DIETARY	-410,314	1,062,606		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,162,475		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-127,208	1,468,655		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23,862	551,954		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-576,070	6,254,196		30.00
31.00	03100	INTENSIVE CARE UNIT	-6,863	1,632,151		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	7,533		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,309,729	4,718,190		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,078		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,407,670		54.00
60.00	06000	LABORATORY	-110,950	4,678,615		60.00
65.00	06500	RESPIRATORY THERAPY	-97,318	675,818		65.00
66.00	06600	PHYSICAL THERAPY	0	2,715,564		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	700,637		67.00
68.00	06800	SPEECH PATHOLOGY	0	339,382		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,226,126		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-249,510	1,309,253		73.00
76.00	03020	OP PSYCH	-352,403	904,763		76.00
76.01	03030	WOUND CARE	-95,435	381,314		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0	2,628,464		88.00
88.01	08801	WOODCREST	0	1,808,202		88.01
88.02	08802	STAT CARE	0	1,618,888		88.02
88.03	08803	BERNE FAMILY MEDICINE	-53,859	1,942,347		88.03
88.04	08804	HIGH STREET	-39,643	1,381,280		88.04
90.00	09000	CLINIC	-2,202,627	2,506,783		90.00
90.01	09001	CLINIC - AMO	-2,012,744	671,491		90.01
90.02	09002	CLINIC - AMH NEURO	-757,002	270,639		90.02
90.03	09003	GENERAL SURGERY OFFICE	-1,656,653	589,724		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	-1,023,503	3,155,425		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-41,166	2,320,372		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,302,407	73,301,410		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	1,177,356		194.01
194.02	07952	OTHER MOBS	0	15,532		194.02
194.03	07953	IDLE SPACE	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	322,219		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,302,407	74,816,517		200.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:49 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB, NURSERY AND L&D				
1.00	NURSERY	43.00	5,237	2,296	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	11,874	5,204	2.00
	0		17,111	7,500	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	83,962	1.00
2.00	OTHER MOBS	194.02	0	15,532	2.00
	0		0	99,494	
	K - RECLASS MOC BUILDING MAINTENACE				
1.00	OPERATION OF PLANT	7.00	0	1,178	1.00
2.00	HOUSEKEEPING	9.00	0	3,951	2.00
3.00	LABORATORY	60.00	0	7,070	3.00
4.00	CLINIC	90.00	0	72,587	4.00
5.00	CLINIC - AMO	90.01	0	21,110	5.00
6.00	GENERAL SURGERY OFFICE	90.03	0	25,625	6.00
	TOTALS		0	131,521	
	L - RECLASS NEURO CLINIC BUILDING COSTS				
1.00	CLINIC - AMH NEURO	90.02	0	24,324	1.00
	TOTALS		0	24,324	
500.00	Grand Total: Increases		17,111	262,839	500.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:49 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB, NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	17,111	7,500	0		1.00
2.00		0.00	0	0	0		2.00
	0		17,111	7,500			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,494	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	99,494			
	K - RECLASS MOC BUILDING MAINTENACE						
1.00	CLINIC	90.00	0	131,521	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
	TOTALS		0	131,521			
	L - RECLASS NEURO CLINIC BUILDING COSTS						
1.00	OTHER NRCC	194.01	0	24,324	0		1.00
	TOTALS		0	24,324			
500.00	Grand Total: Decreases		17,111	262,839			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 8:49 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	473,119	0	0	0	0	1.00
2.00	Land Improvements	2,267,188	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,774,185	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,719,737	0	0	0	0	5.00
6.00	Movable Equipment	20,765,689	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,999,918	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,999,918	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	473,119	0	1.00
2.00	Land Improvements	2,267,188	0	2.00
3.00	Buildings and Fixtures	42,774,185	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	9,719,737	0	5.00
6.00	Movable Equipment	20,765,689	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,999,918	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	75,999,918	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT	1,602,725	0	454,679	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,602,725	0	454,679	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,057,404		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,057,404		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT	54,761,110	0	54,761,110	0.725055	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	20,765,689	0	20,765,689	0.274945	0	2.00
3.00	Total (sum of lines 1-2)	75,526,799	0	75,526,799	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,630,154	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,630,154	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	NEW CAP REL COSTS-BLDG & FIXT	318,944	83,962	0	0	2,033,060	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	318,944	83,962	0	0	2,033,060	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:49 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-141,688	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,445	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,841,749			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	3,076,310			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-410,314	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-249,510	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-23,862	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:49 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	IHA DUES	A	-1,782	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	AHA DUES	A	-3,893	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC AMBULANCE REVENUE	B	-41,166	AMBULANCE SERVICES	95.00	0	33.02
33.03	340B CONTRACT EXPENSES	A	-127,208	PHARMACY	15.00	0	33.03
33.04	WORTHMAN FITNESS CENTER	B	-97,318	RESPIRATORY THERAPY	65.00	0	33.04
33.05	MISC INCOME	B	-8,006	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	EDUCATIONAL SERVICES	B	-22,186	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HOSPITAL PROVIDER TAX SHORTFALL	A	-513,332	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.09	MARKETING	A	-386,809	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN RECRUITING	A	-102,895	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	VALUE ASSIGNMENT/MISC TESTING	B	-110,950	LABORATORY	60.00	0	33.11
33.12	MISC PSYCH INCOME	B	0	OP PSYCH	76.00	0	33.12
34.00	RENTAL INCOME	B	-49,775	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	RENTAL INCOME	B	-53,859	BERNE FAMILY MEDICINE	88.03	0	34.01
34.02	RENTAL INCOME	B	-39,643	HIGH STREET	88.04	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	LAPSE LOSS ON REFINANCING	A	5,953	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05	EAP SERVICES - OP BH	B	-10,280	OP PSYCH	76.00	0	34.05
34.06	NA SCHOOL SERVICES - OP BH	B	-43,000	OP PSYCH	76.00	0	34.06
34.07	COMMUNITY CORRECTIONS SERVICES - OP	B	-98,000	OP PSYCH	76.00	0	34.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,302,407				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 8:49 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE CAPITAL ALLOCATI	90,331	62,902	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE AND IT COSTS	6,057,311	3,706,536	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE AND GROUNDS	1,336,163	638,057	3.00
3.01	0.00			0	0	3.01
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
4.00	0.00			0	0	4.00
5.00	0		0	7,483,805	4,407,495	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 8:49 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	27,429	9		1.00
2.00	2,350,775	0		2.00
3.00	698,106	0		3.00
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
3.06	0	0		3.06
4.00	0	0		4.00
5.00	3,076,310			5.00

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

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

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

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

6.00	MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 8:49 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	30.00	ADULTS & PEDIATRICS	576,070	576,070	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	6,863	6,863	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,309,729	1,309,729	0	0	0	3.00
4.00	76.00	OP PSYCH	201,123	201,123	0	0	0	4.00
5.00	90.00	CLINIC	2,287,023	2,202,627	84,396	0	0	5.00
6.00	90.01	CLINIC - AMO	2,012,744	2,012,744	0	0	0	6.00
7.00	90.02	CLINIC - AMH NEURO	757,002	757,002	0	0	0	7.00
8.00	90.03	GENERAL SURGERY OFFICE	1,701,163	1,656,653	44,510	0	0	8.00
9.00	91.00	EMERGENCY	2,180,449	1,023,503	1,156,946	0	0	9.00
10.00	76.01	WOUND CARE	95,435	95,435	0	0	0	10.00
200.00			11,127,601	9,841,749	1,285,852		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	76.00	OP PSYCH	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	CLINIC - AMO	0	0	0	0	0	6.00
7.00	90.02	CLINIC - AMH NEURO	0	0	0	0	0	7.00
8.00	90.03	GENERAL SURGERY OFFICE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	76.01	WOUND CARE	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	30.00	ADULTS & PEDIATRICS	0	0	0	576,070		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	6,863		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,309,729		3.00
4.00	76.00	OP PSYCH	0	0	0	201,123		4.00
5.00	90.00	CLINIC	0	0	0	2,202,627		5.00
6.00	90.01	CLINIC - AMO	0	0	0	2,012,744		6.00
7.00	90.02	CLINIC - AMH NEURO	0	0	0	757,002		7.00
8.00	90.03	GENERAL SURGERY OFFICE	0	0	0	1,656,653		8.00
9.00	91.00	EMERGENCY	0	0	0	1,023,503		9.00
10.00	76.01	WOUND CARE	0	0	0	95,435		10.00
200.00			0	0	0	9,841,749		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,033,060	2,033,060				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	273,530	0	0	273,530		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,592,630	184,521	0	23,841	14,800,992	5.00
7.00	00700	OPERATION OF PLANT	3,028,062	278,325	0	0	3,306,387	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	285,728	32,340	0	588	318,656	8.00
9.00	00900	HOUSEKEEPING	980,805	53,514	0	4,483	1,038,802	9.00
10.00	01000	DIETARY	1,062,606	127,622	0	4,389	1,194,617	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,162,475	5,911	0	6,104	1,174,490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,468,655	41,749	0	5,970	1,516,374	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	551,954	47,491	0	2,363	601,808	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,254,196	299,310	0	24,840	6,578,346	30.00
31.00	03100	INTENSIVE CARE UNIT	1,632,151	53,757	0	5,165	1,691,073	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7,533	28,001	0	34	35,568	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,718,190	205,096	0	16,639	4,939,925	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,078	28,001	0	77	45,156	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,407,670	165,629	0	9,829	3,583,128	54.00
60.00	06000	LABORATORY	4,678,615	73,434	0	10,589	4,762,638	60.00
65.00	06500	RESPIRATORY THERAPY	675,818	76,483	0	3,795	756,096	65.00
66.00	06600	PHYSICAL THERAPY	2,715,564	170,736	0	13,500	2,899,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	700,637	1,870	0	3,722	706,229	67.00
68.00	06800	SPEECH PATHOLOGY	339,382	935	0	1,895	342,212	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,226,126	0	0	0	1,226,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,253	0	0	0	1,309,253	73.00
76.00	03020	OP PSYCH	904,763	0	0	6,559	911,322	76.00
76.01	03030	WOUND CARE	381,314	0	0	2,377	383,691	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	2,628,464	0	0	12,396	2,640,860	88.00
88.01	08801	WOODCREST	1,808,202	0	0	8,070	1,816,272	88.01
88.02	08802	STAT CARE	1,618,888	42,104	0	7,472	1,668,464	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,942,347	0	0	8,126	1,950,473	88.03
88.04	08804	HIGH STREET	1,381,280	0	0	6,182	1,387,462	88.04
90.00	09000	CLINIC	2,506,783	0	0	20,643	2,527,426	90.00
90.01	09001	CLINIC - AMO	671,491	0	0	14,540	686,031	90.01
90.02	09002	CLINIC - AMH NEURO	270,639	0	0	5,666	276,305	90.02
90.03	09003	GENERAL SURGERY OFFICE	589,724	0	0	9,633	599,357	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,155,425	103,998	0	19,607	3,279,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,320,372	0	0	9,615	2,329,987	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,301,410	2,020,827	0	268,709	73,284,356	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,233	0	0	12,233	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,177,356	0	0	4,821	1,182,177	194.01
194.02	07952	OTHER MOBS	15,532	0	0	0	15,532	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	322,219	0	0	0	322,219	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,816,517	2,033,060	0	273,530	74,816,517	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,800,992					5.00
7.00	00700	OPERATION OF PLANT	815,418	4,121,805				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,587	65,969	463,212			8.00
9.00	00900	HOUSEKEEPING	256,188	109,160	0	1,404,150		9.00
10.00	01000	DIETARY	294,615	260,329	0	93,209	1,842,770	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	289,652	12,057	0	4,317	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	373,967	85,161	0	30,491	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148,417	96,875	0	34,685	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,622,371	610,550	370,474	218,604	1,578,548	30.00
31.00	03100	INTENSIVE CARE UNIT	417,051	109,656	62,011	39,262	264,222	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	8,772	57,117	23,324	20,451	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,218,279	756,227	0	270,762	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,136	57,117	7,403	20,451	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,667	149,795	0	53,633	0	54.00
60.00	06000	LABORATORY	1,174,557	156,014	0	55,860	0	60.00
65.00	06500	RESPIRATORY THERAPY	186,468	348,275	0	124,698	0	65.00
66.00	06600	PHYSICAL THERAPY	715,146	3,815	0	1,366	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,169	1,908	0	683	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,396	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	302,386	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,887	0	0	0	0	73.00
76.00	03020	OP PSYCH	224,749	0	0	0	0	76.00
76.01	03030	WOUND CARE	94,625	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	651,286	0	0	0	0	88.00
88.01	08801	WOODCREST	447,927	0	0	0	0	88.01
88.02	08802	STAT CARE	411,475	85,886	0	30,751	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	481,024	0	0	0	0	88.03
88.04	08804	HIGH STREET	342,174	0	0	0	0	88.04
90.00	09000	CLINIC	623,311	351,480	0	125,846	0	90.00
90.01	09001	CLINIC - AMO	169,188	81,346	0	29,125	0	90.01
90.02	09002	CLINIC - AMH NEURO	68,142	74,592	0	26,707	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	147,813	98,744	0	35,355	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	808,671	212,140	0	75,955	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	574,619	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,423,133	3,784,213	463,212	1,292,211	1,842,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,017	24,953	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	291,547	175,168	0	62,718	0	194.01
194.02	07952	OTHER MOBS	3,830	137,471	0	49,221	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	79,465	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,800,992	4,121,805	463,212	1,404,150	1,842,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,480,516				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	2,005,993		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	881,785	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	525,086	0	0	84,264	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,774	0	0	22,088	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	1,033	0	0	1,388	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	350,426	0	0	89,686	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,343	0	0	1,385	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	182,625	54.00
60.00	06000	LABORATORY	0	0	0	0	131,009	60.00
65.00	06500	RESPIRATORY THERAPY	0	79,924	0	0	31,053	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	38,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	16,021	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	8,791	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	30,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,005,993	66,878	73.00
76.00	03020	OP PSYCH	0	0	0	0	725	76.00
76.01	03030	WOUND CARE	0	0	0	0	3,157	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	16,997	88.00
88.01	08801	WOODCREST	0	0	0	0	14,681	88.01
88.02	08802	STAT CARE	0	0	0	0	16,708	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	13,746	88.03
88.04	08804	HIGH STREET	0	0	0	0	16,570	88.04
90.00	09000	CLINIC	0	0	0	0	17,341	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	5,054	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	1,824	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	3,055	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	412,930	0	0	66,185	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,480,516	0	2,005,993	881,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	764	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,480,516	0	2,005,993	881,785	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,588,243	0	11,588,243		30.00
31.00	03100	INTENSIVE CARE UNIT	2,714,137	0	2,714,137		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
43.00	04300	NURSERY	147,653	0	147,653		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,625,305	0	7,625,305		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,991	0	144,991		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,852,848	0	4,852,848		54.00
60.00	06000	LABORATORY	6,280,078	0	6,280,078		60.00
65.00	06500	RESPIRATORY THERAPY	1,526,514	0	1,526,514		65.00
66.00	06600	PHYSICAL THERAPY	3,659,118	0	3,659,118		66.00
67.00	06700	OCCUPATIONAL THERAPY	899,010	0	899,010		67.00
68.00	06800	SPEECH PATHOLOGY	435,399	0	435,399		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,559,311	0	1,559,311		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,011	0	3,705,011		73.00
76.00	03020	OP PSYCH	1,136,796	0	1,136,796		76.00
76.01	03030	WOUND CARE	481,473	0	481,473		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	3,309,143	0	3,309,143		88.00
88.01	08801	WOODCREST	2,278,880	0	2,278,880		88.01
88.02	08802	STAT CARE	2,213,284	0	2,213,284		88.02
88.03	08803	BERNE FAMILY MEDICINE	2,445,243	0	2,445,243		88.03
88.04	08804	HIGH STREET	1,746,206	0	1,746,206		88.04
90.00	09000	CLINIC	3,645,404	0	3,645,404		90.00
90.01	09001	CLINIC - AMO	970,744	0	970,744		90.01
90.02	09002	CLINIC - AMH NEURO	447,570	0	447,570		90.02
90.03	09003	GENERAL SURGERY OFFICE	884,324	0	884,324		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	4,854,911	0	4,854,911		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,904,606	0	2,904,606		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,456,202	0	72,456,202		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,203	0	40,203		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	1,712,374	0	1,712,374		194.01
194.02	07952	OTHER MOBS	206,054	0	206,054		194.02
194.03	07953	IDLE SPACE	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	401,684	0	401,684		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	74,816,517	0	74,816,517		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	184,521	0	184,521	0	5.00
7.00	00700	OPERATION OF PLANT	0	278,325	0	278,325	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,340	0	32,340	0	8.00
9.00	00900	HOUSEKEEPING	0	53,514	0	53,514	0	9.00
10.00	01000	DIETARY	0	127,622	0	127,622	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,911	0	5,911	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	41,749	0	41,749	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,491	0	47,491	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	299,310	0	299,310	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,757	0	53,757	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	28,001	0	28,001	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	205,096	0	205,096	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,001	0	28,001	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	165,629	0	165,629	0	54.00
60.00	06000	LABORATORY	0	73,434	0	73,434	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	76,483	0	76,483	0	65.00
66.00	06600	PHYSICAL THERAPY	0	170,736	0	170,736	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,870	0	1,870	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	935	0	935	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	42,104	0	42,104	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	103,998	0	103,998	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,020,827	0	2,020,827	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,233	0	12,233	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,033,060	0	2,033,060	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	184,521					5.00
7.00	00700	OPERATION OF PLANT	10,167	288,492				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	980	4,617	37,937			8.00
9.00	00900	HOUSEKEEPING	3,194	7,640	0	64,348		9.00
10.00	01000	DIETARY	3,673	18,221	0	4,272	153,788	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,612	844	0	198	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,663	5,961	0	1,397	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,851	6,780	0	1,590	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,200	42,733	30,342	10,018	131,737	30.00
31.00	03100	INTENSIVE CARE UNIT	5,200	7,675	5,079	1,799	22,051	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	109	3,998	1,910	937	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,190	52,929	0	12,407	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139	3,998	606	937	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,018	10,484	0	2,458	0	54.00
60.00	06000	LABORATORY	14,645	10,920	0	2,560	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,325	24,376	0	5,715	0	65.00
66.00	06600	PHYSICAL THERAPY	8,917	267	0	63	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,172	134	0	31	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,052	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,770	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,026	0	0	0	0	73.00
76.00	03020	OP PSYCH	2,802	0	0	0	0	76.00
76.01	03030	WOUND CARE	1,180	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	8,121	0	0	0	0	88.00
88.01	08801	WOODCREST	5,585	0	0	0	0	88.01
88.02	08802	STAT CARE	5,131	6,011	0	1,409	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	5,998	0	0	0	0	88.03
88.04	08804	HIGH STREET	4,266	0	0	0	0	88.04
90.00	09000	CLINIC	7,772	24,601	0	5,767	0	90.00
90.01	09001	CLINIC - AMO	2,110	5,694	0	1,335	0	90.01
90.02	09002	CLINIC - AMH NEURO	850	5,221	0	1,224	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1,843	6,911	0	1,620	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	10,083	14,848	0	3,481	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,165	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,809	264,863	37,937	59,218	153,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	1,747	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	3,635	12,260	0	2,874	0	194.01
194.02	07952	OTHER MOBS	48	9,622	0	2,256	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	991	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	184,521	288,492	37,937	64,348	153,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	10,565				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	53,770		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	57,712	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,747	0	0	5,512	30.00
31.00	03100	INTENSIVE CARE UNIT	0	776	0	0	1,445	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	7	0	0	91	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,501	0	0	5,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17	0	0	91	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	11,975	54.00
60.00	06000	LABORATORY	0	0	0	0	8,570	60.00
65.00	06500	RESPIRATORY THERAPY	0	570	0	0	2,031	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,048	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	575	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,770	4,375	73.00
76.00	03020	OP PSYCH	0	0	0	0	47	76.00
76.01	03030	WOUND CARE	0	0	0	0	207	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	1,112	88.00
88.01	08801	WOODCREST	0	0	0	0	960	88.01
88.02	08802	STAT CARE	0	0	0	0	1,093	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	899	88.03
88.04	08804	HIGH STREET	0	0	0	0	1,084	88.04
90.00	09000	CLINIC	0	0	0	0	1,134	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	331	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	119	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	200	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	2,947	0	0	4,330	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,565	0	53,770	57,662	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	50	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,565	0	53,770	57,712	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:49 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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	543,599	0	543,599		30.00
31.00	03100	INTENSIVE CARE UNIT	97,782	0	97,782		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
43.00	04300	NURSERY	35,053	0	35,053		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	293,990	0	293,990		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,789	0	33,789		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,564	0	201,564		54.00
60.00	06000	LABORATORY	110,129	0	110,129		60.00
65.00	06500	RESPIRATORY THERAPY	111,500	0	111,500		65.00
66.00	06600	PHYSICAL THERAPY	182,534	0	182,534		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,255	0	5,255		67.00
68.00	06800	SPEECH PATHOLOGY	2,562	0	2,562		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,785	0	5,785		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,171	0	62,171		73.00
76.00	03020	OP PSYCH	2,849	0	2,849		76.00
76.01	03030	WOUND CARE	1,387	0	1,387		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	9,233	0	9,233		88.00
88.01	08801	WOODCREST	6,545	0	6,545		88.01
88.02	08802	STAT CARE	55,748	0	55,748		88.02
88.03	08803	BERNE FAMILY MEDICINE	6,897	0	6,897		88.03
88.04	08804	HIGH STREET	5,350	0	5,350		88.04
90.00	09000	CLINIC	39,274	0	39,274		90.00
90.01	09001	CLINIC - AMO	9,470	0	9,470		90.01
90.02	09002	CLINIC - AMH NEURO	7,414	0	7,414		90.02
90.03	09003	GENERAL SURGERY OFFICE	10,574	0	10,574		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	139,687	0	139,687		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	7,165	0	7,165		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,987,306	0	1,987,306		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,018	0	14,018		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	18,819	0	18,819		194.01
194.02	07952	OTHER MOBS	11,926	0	11,926		194.02
194.03	07953	IDLE SPACE	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	991	0	991		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,033,060	0	2,033,060		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	108,693					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	41,994,545			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,865	0	3,660,492	-14,800,992	60,015,525	5.00
7.00	00700	OPERATION OF PLANT	14,880	0	0	0	3,306,387	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	90,205	0	318,656	8.00
9.00	00900	HOUSEKEEPING	2,861	0	688,332	0	1,038,802	9.00
10.00	01000	DIETARY	6,823	0	673,838	0	1,194,617	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316	0	937,273	0	1,174,490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,232	0	916,554	0	1,516,374	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	362,765	0	601,808	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,002	0	3,810,942	0	6,578,346	30.00
31.00	03100	INTENSIVE CARE UNIT	2,874	0	792,995	0	1,691,073	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,497	0	5,237	0	35,568	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	2,554,704	0	4,939,925	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497	0	11,874	0	45,156	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	1,509,142	0	3,583,128	54.00
60.00	06000	LABORATORY	3,926	0	1,625,859	0	4,762,638	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	582,666	0	756,096	65.00
66.00	06600	PHYSICAL THERAPY	9,128	0	2,072,819	0	2,899,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	571,506	0	706,229	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	290,919	0	342,212	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,226,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,309,253	73.00
76.00	03020	OP PSYCH	0	0	1,007,007	0	911,322	76.00
76.01	03030	WOUND CARE	0	0	365,010	0	383,691	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	1,903,251	0	2,640,860	88.00
88.01	08801	WOODCREST	0	0	1,239,123	0	1,816,272	88.01
88.02	08802	STAT CARE	2,251	0	1,147,285	0	1,668,464	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	1,247,672	0	1,950,473	88.03
88.04	08804	HIGH STREET	0	0	949,239	0	1,387,462	88.04
90.00	09000	CLINIC	0	0	3,169,456	0	2,527,426	90.00
90.01	09001	CLINIC - AMO	0	0	2,232,528	0	686,031	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	869,971	0	276,305	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	1,478,983	0	599,357	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,560	0	3,010,376	0	3,279,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,476,252	0	2,329,987	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,039	0	41,254,275	-14,800,992	58,483,364	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	12,233	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	740,270	0	1,182,177	194.01
194.02	07952	OTHER MOBS	0	0	0	0	15,532	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	322,219	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)	2,033,060	0	273,530		14,800,992	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.704608	0.000000	0.006513		0.246619	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			0		184,521	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.003075	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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (NOT USED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	108,029					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	5,819				8.00
9.00	00900	HOUSEKEEPING	2,861	0	102,785			9.00
10.00	01000	DIETARY	6,823	0	6,823	5,433		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316	0	316	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,232	0	2,232	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,002	4,654	16,002	4,654	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,874	779	2,874	779	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,497	293	1,497	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,820	0	19,820	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497	93	1,497	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,926	0	3,926	0	0	54.00
60.00	06000	LABORATORY	4,089	0	4,089	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,128	0	9,128	0	0	65.00
66.00	06600	PHYSICAL THERAPY	100	0	100	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	50	0	50	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	2,251	0	2,251	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	9,212	0	9,212	0	0	90.00
90.01	09001	CLINIC - AMO	2,132	0	2,132	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1,955	0	1,955	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2,588	0	2,588	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,560	0	5,560	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,181	5,819	94,591	5,433	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	4,591	0	4,591	0	0	194.01
194.02	07952	OTHER MOBS	3,603	0	3,603	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	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)	4,121,805	463,212	1,404,150	1,842,770	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.154616	79.603368	13.661040	339.180931	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	288,492	37,937	64,348	153,788	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.670505	6.519505	0.626045	28.306276	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (NOT USED)	
			7.00	8.00	9.00	10.00	11.00	
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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,793,405					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	117,238,241		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,828,053	0	0	11,203,776		30.00
31.00	03100	INTENSIVE CARE UNIT	792,995	0	0	2,936,838		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	7,533	0	0	184,508		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,554,704	0	0	11,924,727		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,078	0	0	184,160		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,277,487		54.00
60.00	06000	LABORATORY	0	0	0	17,419,118		60.00
65.00	06500	RESPIRATORY THERAPY	582,666	0	0	4,128,809		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,184,297		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,130,190		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,168,844		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,095,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	8,892,108		73.00
76.00	03020	OP PSYCH	0	0	0	96,383		76.00
76.01	03030	WOUND CARE	0	0	0	419,726		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	2,259,889		88.00
88.01	08801	WOODCREST	0	0	0	1,951,988		88.01
88.02	08802	STAT CARE	0	0	0	2,221,560		88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	1,827,639		88.03
88.04	08804	HIGH STREET	0	0	0	2,203,202		88.04
90.00	09000	CLINIC	0	0	0	2,305,617		90.00
90.01	09001	CLINIC - AMO	0	0	0	672,008		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	242,497		90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	406,189		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0		90.04
91.00	09100	EMERGENCY	3,010,376	0	0	8,800,003		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		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,793,405	0	100	117,136,692		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	TITLE XX	0	0	0	0		194.00
194.01	07951	OTHER NRCC	0	0	0	101,549		194.01
194.02	07952	OTHER MOBS	0	0	0	0		194.02
194.03	07953	IDLE SPACE	0	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	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)	1,480,516	0	2,005,993	881,785		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.137169	0.000000	20,059.930000	0.007521		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,565	0	53,770	57,712		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:49 am

		Cost Center Description	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000979	0.000000	537.700000	0.000492		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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 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	11,588,243		11,588,243	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,714,137		2,714,137	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	147,653		147,653	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,625,305		7,625,305	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,991		144,991	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,852,848		4,852,848	0	0	54.00
60.00	06000	LABORATORY	6,280,078		6,280,078	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,526,514	0	1,526,514	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,659,118	0	3,659,118	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,010	0	899,010	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	435,399	0	435,399	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,559,311		1,559,311	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,011		3,705,011	0	0	73.00
76.00	03020	OP PSYCH	1,136,796		1,136,796	0	0	76.00
76.01	03030	WOUND CARE	481,473		481,473	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	3,309,143		3,309,143	0	0	88.00
88.01	08801	WOODCREST	2,278,880		2,278,880	0	0	88.01
88.02	08802	STAT CARE	2,213,284		2,213,284	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	2,445,243		2,445,243	0	0	88.03
88.04	08804	HIGH STREET	1,746,206		1,746,206	0	0	88.04
90.00	09000	CLINIC	3,645,404		3,645,404	0	0	90.00
90.01	09001	CLINIC - AMO	970,744		970,744	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	447,570		447,570	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	884,324		884,324	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,854,911		4,854,911	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,824,262		4,824,262		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,904,606		2,904,606	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	77,280,464	0	77,280,464	0	0	200.00
201.00		Less Observation Beds	4,824,262		4,824,262		0	201.00
202.00		Total (see instructions)	72,456,202	0	72,456,202	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 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	7,008,151		7,008,151			30.00
31.00	03100	INTENSIVE CARE UNIT	2,852,214		2,852,214			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	230,668		230,668			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,427,420	13,062,503	14,489,923	0.526249	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,683	7,073	226,756	0.639414	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,385	27,127,809	28,580,194	0.169798	0.000000	54.00
60.00	06000	LABORATORY	2,204,995	17,933,565	20,138,560	0.311843	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,268,575	3,531,221	4,799,796	0.318037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	396,118	5,500,855	5,896,973	0.620508	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,920	1,937,051	2,373,971	0.378695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,588	1,260,428	1,326,016	0.328351	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	534,945	3,483,873	4,018,818	0.388002	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,661,769	6,612,396	9,274,165	0.399498	0.000000	73.00
76.00	03020	OP PSYCH	0	66,868	66,868	17.000598	0.000000	76.00
76.01	03030	WOUND CARE	750	213,758	214,508	2.244546	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	3,179,905	3,179,905			88.00
88.01	08801	WOODCREST	0	2,198,786	2,198,786			88.01
88.02	08802	STAT CARE	0	2,093,132	2,093,132			88.02
88.03	08803	BERNE FAMILY MEDICINE	0	2,162,034	2,162,034			88.03
88.04	08804	HIGH STREET	0	2,445,984	2,445,984			88.04
90.00	09000	CLINIC	400	2,369,534	2,369,934	1.538188	0.000000	90.00
90.01	09001	CLINIC - AMO	0	739,563	739,563	1.312591	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	283,476	283,476	1.578864	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	366,070	366,070	2.415724	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	20,000	10,064,871	10,084,871	0.481405	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	251,885	3,681,695	3,933,580	1.226430	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,185,077	2,185,077	1.329292	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,032,466	112,507,527	133,539,993			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,032,466	112,507,527	133,539,993			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OP PSYCH	0.000000		76.00
76.01	03030	WOUND CARE	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	MONROE FAMILY MEDICINE			88.00
88.01	08801	WOODCREST			88.01
88.02	08802	STAT CARE			88.02
88.03	08803	BERNE FAMILY MEDICINE			88.03
88.04	08804	HIGH STREET			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - AMO	0.000000		90.01
90.02	09002	CLINIC - AMH NEURO	0.000000		90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000		90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,588,243		11,588,243	0	11,588,243	30.00
31.00	03100	INTENSIVE CARE UNIT	2,714,137		2,714,137	0	2,714,137	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	147,653		147,653	0	147,653	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,625,305		7,625,305	0	7,625,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,991		144,991	0	144,991	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,852,848		4,852,848	0	4,852,848	54.00
60.00	06000	LABORATORY	6,280,078		6,280,078	0	6,280,078	60.00
65.00	06500	RESPIRATORY THERAPY	1,526,514	0	1,526,514	0	1,526,514	65.00
66.00	06600	PHYSICAL THERAPY	3,659,118	0	3,659,118	0	3,659,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,010	0	899,010	0	899,010	67.00
68.00	06800	SPEECH PATHOLOGY	435,399	0	435,399	0	435,399	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,559,311		1,559,311	0	1,559,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,011		3,705,011	0	3,705,011	73.00
76.00	03020	OP PSYCH	1,136,796		1,136,796	0	1,136,796	76.00
76.01	03030	WOUND CARE	481,473		481,473	0	481,473	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	3,309,143		3,309,143	0	3,309,143	88.00
88.01	08801	WOODCREST	2,278,880		2,278,880	0	2,278,880	88.01
88.02	08802	STAT CARE	2,213,284		2,213,284	0	2,213,284	88.02
88.03	08803	BERNE FAMILY MEDICINE	2,445,243		2,445,243	0	2,445,243	88.03
88.04	08804	HIGH STREET	1,746,206		1,746,206	0	1,746,206	88.04
90.00	09000	CLINIC	3,645,404		3,645,404	0	3,645,404	90.00
90.01	09001	CLINIC - AMO	970,744		970,744	0	970,744	90.01
90.02	09002	CLINIC - AMH NEURO	447,570		447,570	0	447,570	90.02
90.03	09003	GENERAL SURGERY OFFICE	884,324		884,324	0	884,324	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,854,911		4,854,911	0	4,854,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,824,262		4,824,262		4,824,262	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,904,606		2,904,606	0	2,904,606	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	77,280,464	0	77,280,464	0	77,280,464	200.00
201.00		Less Observation Beds	4,824,262		4,824,262		4,824,262	201.00
202.00		Total (see instructions)	72,456,202	0	72,456,202	0	72,456,202	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		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	7,008,151		7,008,151			30.00
31.00	03100	INTENSIVE CARE UNIT	2,852,214		2,852,214			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	230,668		230,668			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,427,420	13,062,503	14,489,923	0.526249	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,683	7,073	226,756	0.639414	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,385	27,127,809	28,580,194	0.169798	0.000000	54.00
60.00	06000	LABORATORY	2,204,995	17,933,565	20,138,560	0.311843	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,268,575	3,531,221	4,799,796	0.318037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	396,118	5,500,855	5,896,973	0.620508	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,920	1,937,051	2,373,971	0.378695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,588	1,260,428	1,326,016	0.328351	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	534,945	3,483,873	4,018,818	0.388002	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,661,769	6,612,396	9,274,165	0.399498	0.000000	73.00
76.00	03020	OP PSYCH	0	66,868	66,868	17.000598	0.000000	76.00
76.01	03030	WOUND CARE	750	213,758	214,508	2.244546	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	3,179,905	3,179,905	1.040642	0.000000	88.00
88.01	08801	WOODCREST	0	2,198,786	2,198,786	1.036426	0.000000	88.01
88.02	08802	STAT CARE	0	2,093,132	2,093,132	1.057403	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	2,162,034	2,162,034	1.130992	0.000000	88.03
88.04	08804	HIGH STREET	0	2,445,984	2,445,984	0.713907	0.000000	88.04
90.00	09000	CLINIC	400	2,369,534	2,369,934	1.538188	0.000000	90.00
90.01	09001	CLINIC - AMO	0	739,563	739,563	1.312591	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	283,476	283,476	1.578864	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	366,070	366,070	2.415724	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	20,000	10,064,871	10,084,871	0.481405	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	251,885	3,681,695	3,933,580	1.226430	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,185,077	2,185,077	1.329292	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,032,466	112,507,527	133,539,993			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,032,466	112,507,527	133,539,993			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.526249		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798		54.00
60.00	06000	LABORATORY	0.311843		60.00
65.00	06500	RESPIRATORY THERAPY	0.318037		65.00
66.00	06600	PHYSICAL THERAPY	0.620508		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695		67.00
68.00	06800	SPEECH PATHOLOGY	0.328351		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498		73.00
76.00	03020	OP PSYCH	17.000598		76.00
76.01	03030	WOUND CARE	2.244546		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	MONROE FAMILY MEDICINE	1.040642		88.00
88.01	08801	WOODCREST	1.036426		88.01
88.02	08802	STAT CARE	1.057403		88.02
88.03	08803	BERNE FAMILY MEDICINE	1.130992		88.03
88.04	08804	HIGH STREET	0.713907		88.04
90.00	09000	CLINIC	1.538188		90.00
90.01	09001	CLINIC - AMO	1.312591		90.01
90.02	09002	CLINIC - AMH NEURO	1.578864		90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000		90.04
91.00	09100	EMERGENCY	0.481405		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1.329292		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,625,305	293,990	7,331,315	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,991	33,789	111,202	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,852,848	201,564	4,651,284	0	0	54.00
60.00	06000	LABORATORY	6,280,078	110,129	6,169,949	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,526,514	111,500	1,415,014	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,659,118	182,534	3,476,584	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,010	5,255	893,755	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	435,399	2,562	432,837	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,559,311	5,785	1,553,526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,011	62,171	3,642,840	0	0	73.00
76.00	03020	OP PSYCH	1,136,796	2,849	1,133,947	0	0	76.00
76.01	03030	WOUND CARE	481,473	1,387	480,086	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	3,309,143	9,233	3,299,910	0	0	88.00
88.01	08801	WOODCREST	2,278,880	6,545	2,272,335	0	0	88.01
88.02	08802	STAT CARE	2,213,284	55,748	2,157,536	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	2,445,243	6,897	2,438,346	0	0	88.03
88.04	08804	HIGH STREET	1,746,206	5,350	1,740,856	0	0	88.04
90.00	09000	CLINIC	3,645,404	39,274	3,606,130	0	0	90.00
90.01	09001	CLINIC - AMO	970,744	9,470	961,274	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	447,570	7,414	440,156	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	884,324	10,574	873,750	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,854,911	139,687	4,715,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,824,262	226,306	4,597,956	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,904,606	7,165	2,897,441	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	62,830,431	1,537,178	61,293,253	0	0	200.00
201.00		Less Observation Beds	4,824,262	226,306	4,597,956	0	0	201.00
202.00		Total (line 200 minus line 201)	58,006,169	1,310,872	56,695,297	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,625,305	14,489,923	0.526249		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,991	226,756	0.639414		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,852,848	28,580,194	0.169798		54.00
60.00	06000	LABORATORY	6,280,078	20,138,560	0.311843		60.00
65.00	06500	RESPIRATORY THERAPY	1,526,514	4,799,796	0.318037		65.00
66.00	06600	PHYSICAL THERAPY	3,659,118	5,896,973	0.620508		66.00
67.00	06700	OCCUPATIONAL THERAPY	899,010	2,373,971	0.378695		67.00
68.00	06800	SPEECH PATHOLOGY	435,399	1,326,016	0.328351		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,559,311	4,018,818	0.388002		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,011	9,274,165	0.399498		73.00
76.00	03020	OP PSYCH	1,136,796	66,868	17.000598		76.00
76.01	03030	WOUND CARE	481,473	214,508	2.244546		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	3,309,143	3,179,905	1.040642		88.00
88.01	08801	WOODCREST	2,278,880	2,198,786	1.036426		88.01
88.02	08802	STAT CARE	2,213,284	2,093,132	1.057403		88.02
88.03	08803	BERNE FAMILY MEDICINE	2,445,243	2,162,034	1.130992		88.03
88.04	08804	HIGH STREET	1,746,206	2,445,984	0.713907		88.04
90.00	09000	CLINIC	3,645,404	2,369,934	1.538188		90.00
90.01	09001	CLINIC - AMO	970,744	739,563	1.312591		90.01
90.02	09002	CLINIC - AMH NEURO	447,570	283,476	1.578864		90.02
90.03	09003	GENERAL SURGERY OFFICE	884,324	366,070	2.415724		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000		90.04
91.00	09100	EMERGENCY	4,854,911	10,084,871	0.481405		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,824,262	3,933,580	1.226430		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,904,606	2,185,077	1.329292		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	62,830,431	123,448,960			200.00
201.00		Less Observation Beds	4,824,262	0			201.00
202.00		Total (line 200 minus line 201)	58,006,169	123,448,960			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 8:49 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	293,990	14,489,923	0.020289	422,395	8,570	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,789	226,756	0.149010	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,564	28,580,194	0.007053	456,198	3,218	54.00
60.00	06000	LABORATORY	110,129	20,138,560	0.005469	412,052	2,254	60.00
65.00	06500	RESPIRATORY THERAPY	111,500	4,799,796	0.023230	444,205	10,319	65.00
66.00	06600	PHYSICAL THERAPY	182,534	5,896,973	0.030954	113,042	3,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,255	2,373,971	0.002214	114,924	254	67.00
68.00	06800	SPEECH PATHOLOGY	2,562	1,326,016	0.001932	21,981	42	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,785	4,018,818	0.001439	217,319	313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,171	9,274,165	0.006704	734,359	4,923	73.00
76.00	03020	OP PSYCH	2,849	66,868	0.042606	0	0	76.00
76.01	03030	WOUND CARE	1,387	214,508	0.006466	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	9,233	3,179,905	0.002904	0	0	88.00
88.01	08801	WOODCREST	6,545	2,198,786	0.002977	0	0	88.01
88.02	08802	STAT CARE	55,748	2,093,132	0.026634	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	6,897	2,162,034	0.003190	0	0	88.03
88.04	08804	HIGH STREET	5,350	2,445,984	0.002187	0	0	88.04
90.00	09000	CLINIC	39,274	2,369,934	0.016572	380	6	90.00
90.01	09001	CLINIC - AMO	9,470	739,563	0.012805	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	7,414	283,476	0.026154	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	10,574	366,070	0.028885	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	139,687	10,084,871	0.013851	6,382	88	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	226,306	3,933,580	0.057532	4,911	283	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	1,530,013	121,263,883		2,948,148	33,769	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 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	14,489,923	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	226,756	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,580,194	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,138,560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,799,796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,896,973	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,373,971	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,326,016	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,018,818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,274,165	0.000000	73.00
76.00	03020	OP PSYCH	0	0	0	66,868	0.000000	76.00
76.01	03030	WOUND CARE	0	0	0	214,508	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	3,179,905	0.000000	88.00
88.01	08801	WOODCREST	0	0	0	2,198,786	0.000000	88.01
88.02	08802	STAT CARE	0	0	0	2,093,132	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	2,162,034	0.000000	88.03
88.04	08804	HIGH STREET	0	0	0	2,445,984	0.000000	88.04
90.00	09000	CLINIC	0	0	0	2,369,934	0.000000	90.00
90.01	09001	CLINIC - AMO	0	0	0	739,563	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	283,476	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	366,070	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	10,084,871	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,933,580	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	121,263,883		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 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	422,395	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	456,198	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	412,052	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	444,205	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	113,042	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	114,924	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	21,981	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	217,319	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	734,359	0	0	0	73.00
76.00	03020	OP PSYCH	0.000000	0	0	0	0	76.00
76.01	03030	WOUND CARE	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0.000000	0	0	0	0	88.00
88.01	08801	WOODCREST	0.000000	0	0	0	0	88.01
88.02	08802	STAT CARE	0.000000	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000	0	0	0	0	88.03
88.04	08804	HIGH STREET	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	380	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.000000	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	6,382	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,911	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		2,948,148	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:49 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	0.526249	0	3,062,804	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	0	6,902,615	0	0	54.00
60.00	06000	LABORATORY	0.311843	0	3,947,188	1,228	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	0	766,982	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	0	1,606,616	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	0	431,054	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	0	83,572	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	0	1,134,732	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	0	1,566,706	28,999	0	73.00
76.00	03020	OP PSYCH	17.000598	0	9,157	0	0	76.00
76.01	03030	WOUND CARE	2.244546	0	3,909	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE						88.00
88.01	08801	WOODCREST						88.01
88.02	08802	STAT CARE						88.02
88.03	08803	BERNE FAMILY MEDICINE						88.03
88.04	08804	HIGH STREET						88.04
90.00	09000	CLINIC	1.538188	0	317,392	10,557	0	90.00
90.01	09001	CLINIC - AMO	1.312591	0	243,097	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	33,476	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	49,058	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.481405	0	1,646,821	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	0	1,166,198	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.329292		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	22,971,377	40,784	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	22,971,377	40,784	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:49 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	1,611,798	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,172,050	0		54.00
60.00	06000	LABORATORY	1,230,903	383		60.00
65.00	06500	RESPIRATORY THERAPY	243,929	0		65.00
66.00	06600	PHYSICAL THERAPY	996,918	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	163,238	0		67.00
68.00	06800	SPEECH PATHOLOGY	27,441	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	440,278	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	625,896	11,585		73.00
76.00	03020	OP PSYCH	155,674	0		76.00
76.01	03030	WOUND CARE	8,774	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE				88.00
88.01	08801	WOODCREST				88.01
88.02	08802	STAT CARE				88.02
88.03	08803	BERNE FAMILY MEDICINE				88.03
88.04	08804	HIGH STREET				88.04
90.00	09000	CLINIC	488,209	16,239		90.00
90.01	09001	CLINIC - AMO	319,087	0		90.01
90.02	09002	CLINIC - AMH NEURO	52,854	0		90.02
90.03	09003	GENERAL SURGERY OFFICE	118,511	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	792,788	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,430,260	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	9,878,608	28,207		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,878,608	28,207		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | Swing Beds - SNF | 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	0.526249	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	0	0	0	0	54.00
60.00	06000	LABORATORY	0.311843	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	0	0	0	0	73.00
76.00	03020	OP PSYCH	17.000598	0	0	0	0	76.00
76.01	03030	WOUND CARE	2.244546	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE						88.00
88.01	08801	WOODCREST						88.01
88.02	08802	STAT CARE						88.02
88.03	08803	BERNE FAMILY MEDICINE						88.03
88.04	08804	HIGH STREET						88.04
90.00	09000	CLINIC	1.538188	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	1.312591	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.481405	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.329292		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
76.01	03030	WOUND CARE	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE				88.00
88.01	08801	WOODCREST				88.01
88.02	08802	STAT CARE				88.02
88.03	08803	BERNE FAMILY MEDICINE				88.03
88.04	08804	HIGH STREET				88.04
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	543,599	107,344	436,255	3,628	120.25	30.00
31.00	INTENSIVE CARE UNIT	97,782		97,782	779	125.52	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	35,053		35,053	293	119.63	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	676,434		569,090	4,700		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	131	16,443	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	107	12,800	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	238	29,243	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	293,990	14,489,923	0.020289	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,789	226,756	0.149010	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,564	28,580,194	0.007053	0	0	54.00
60.00	06000	LABORATORY	110,129	20,138,560	0.005469	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	111,500	4,799,796	0.023230	0	0	65.00
66.00	06600	PHYSICAL THERAPY	182,534	5,896,973	0.030954	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,255	2,373,971	0.002214	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,562	1,326,016	0.001932	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,785	4,018,818	0.001439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,171	9,274,165	0.006704	0	0	73.00
76.00	03020	OP PSYCH	2,849	66,868	0.042606	0	0	76.00
76.01	03030	WOUND CARE	1,387	214,508	0.006466	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	9,233	3,179,905	0.002904	0	0	88.00
88.01	08801	WOODCREST	6,545	2,198,786	0.002977	0	0	88.01
88.02	08802	STAT CARE	55,748	2,093,132	0.026634	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	6,897	2,162,034	0.003190	0	0	88.03
88.04	08804	HIGH STREET	5,350	2,445,984	0.002187	0	0	88.04
90.00	09000	CLINIC	39,274	2,369,934	0.016572	0	0	90.00
90.01	09001	CLINIC - AMO	9,470	739,563	0.012805	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	7,414	283,476	0.026154	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	10,574	366,070	0.028885	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	139,687	10,084,871	0.013851	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	226,306	3,933,580	0.057532	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	1,530,013	121,263,883		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,628	0.00	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	779	0.00	131	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	293	0.00	107	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	4,700		238	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,489,923	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	226,756	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,580,194	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,138,560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,799,796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,896,973	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,373,971	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,326,016	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,018,818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,274,165	0.000000	73.00
76.00	03020	OP PSYCH	0	0	0	66,868	0.000000	76.00
76.01	03030	WOUND CARE	0	0	0	214,508	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	3,179,905	0.000000	88.00
88.01	08801	WOODCREST	0	0	0	2,198,786	0.000000	88.01
88.02	08802	STAT CARE	0	0	0	2,093,132	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	2,162,034	0.000000	88.03
88.04	08804	HIGH STREET	0	0	0	2,445,984	0.000000	88.04
90.00	09000	CLINIC	0	0	0	2,369,934	0.000000	90.00
90.01	09001	CLINIC - AMO	0	0	0	739,563	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	283,476	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	366,070	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	10,084,871	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,933,580	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	121,263,883		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	OP PSYCH	0.000000	0	0	0	0	76.00
76.01	03030	WOUND CARE	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0.000000	0	0	0	0	88.00
88.01	08801	WOODCREST	0.000000	0	0	0	0	88.01
88.02	08802	STAT CARE	0.000000	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000	0	0	0	0	88.03
88.04	08804	HIGH STREET	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.000000	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,628	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,746	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	885	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	141	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	840	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)	458	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,588,243	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	19,740	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,288,322	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,299,921	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,299,921	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)	2,563.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,153,231	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,153,231	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,714,137	779	3,484.13	175	609,723	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,077,773	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)	3,840,727	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,174,023	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,174,023	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,882	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,563.37	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,824,262	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	543,599	11,588,243	0.046910	4,824,262	226,306	90.00
91.00	Nursing Program cost	0	11,588,243	0.000000	4,824,262	0	91.00
92.00	Allied health cost	0	11,588,243	0.000000	4,824,262	0	92.00
93.00	All other Medical Education	0	11,588,243	0.000000	4,824,262	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,628	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,746	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	885	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	141	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	293	15.00
16.00	Nursery days (title V or XIX only)	107	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	140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,588,243	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	19,740	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,288,322	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,299,921	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,299,921	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)	2,563.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	147,653	293	503.94	107	53,922	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,714,137	779	3,484.13	131	456,421	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)	0	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)	510,343	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)	29,243	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)	29,243	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	481,100	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,882	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,563.37	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,824,262	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	543,599	11,588,243	0.046910	4,824,262	226,306	90.00
91.00	Nursing Program cost	0	11,588,243	0.000000	4,824,262	0	91.00
92.00	Allied health cost	0	11,588,243	0.000000	4,824,262	0	92.00
93.00	All other Medical Education	0	11,588,243	0.000000	4,824,262	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:49 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		1,454,778		30.00
31.00	03100	INTENSIVE CARE UNIT		995,892		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.526249	422,395	222,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	456,198	77,462	54.00
60.00	06000	LABORATORY	0.311843	412,052	128,496	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	444,205	141,274	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	113,042	70,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	114,924	43,521	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	21,981	7,217	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	217,319	84,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	734,359	293,375	73.00
76.00	03020	OP PSYCH	17.000598	0	0	76.00
76.01	03030	WOUND CARE	2.244546	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0.000000		0	88.00
88.01	08801	WOODCREST	0.000000		0	88.01
88.02	08802	STAT CARE	0.000000		0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000		0	88.03
88.04	08804	HIGH STREET	0.000000		0	88.04
90.00	09000	CLINIC	1.538188	380	585	90.00
90.01	09001	CLINIC - AMO	1.312591	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.481405	6,382	3,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	4,911	6,023	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,948,148	1,077,773	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)		2,948,148		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z330 | Date/Time Prepared: 5/29/2024 8:49 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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.526249	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	14,664	2,490	54.00
60.00	06000	LABORATORY	0.311843	57,757	18,011	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	57,955	18,432	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	83,417	51,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	103,572	39,222	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	5,427	1,782	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	201,548	80,518	73.00
76.00	03020	OP PSYCH	17.000598	0	0	76.00
76.01	03030	WOUND CARE	2.244546	203	456	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0.000000		0	88.00
88.01	08801	WOODCREST	0.000000		0	88.01
88.02	08802	STAT CARE	0.000000		0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000		0	88.03
88.04	08804	HIGH STREET	0.000000		0	88.04
90.00	09000	CLINIC	1.538188	0	0	90.00
90.01	09001	CLINIC - AMO	1.312591	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.481405	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		524,543	212,672	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)		524,543		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.526249	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	0	0	54.00
60.00	06000	LABORATORY	0.311843	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	0	0	73.00
76.00	03020	OP PSYCH	17.000598	0	0	76.00
76.01	03030	WOUND CARE	2.244546	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	1.040642	0	0	88.00
88.01	08801	WOODCREST	1.036426	0	0	88.01
88.02	08802	STAT CARE	1.057403	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1.130992	0	0	88.03
88.04	08804	HIGH STREET	0.713907	0	0	88.04
90.00	09000	CLINIC	1.538188	0	0	90.00
90.01	09001	CLINIC - AMO	1.312591	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.481405	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z330 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.526249	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.639414	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169798	0	0	54.00
60.00	06000	LABORATORY	0.311843	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.318037	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.620508	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378695	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.328351	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.388002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399498	0	0	73.00
76.00	03020	OP PSYCH	17.000598	0	0	76.00
76.01	03030	WOUND CARE	2.244546	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	1.040642	0	0	88.00
88.01	08801	WOODCREST	1.036426	0	0	88.01
88.02	08802	STAT CARE	1.057403	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1.130992	0	0	88.03
88.04	08804	HIGH STREET	0.713907	0	0	88.04
90.00	09000	CLINIC	1.538188	0	0	90.00
90.01	09001	CLINIC - AMO	1.312591	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.578864	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2.415724	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.481405	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.226430	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,906,815	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,906,815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	10,005,883	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)	104,121	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,701,738	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)	6,200,024	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	6,200,024	30.00
31.00	Primary payer payments	16,376	31.00
32.00	Subtotal (line 30 minus line 31)	6,183,648	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)	181,996	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	118,297	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	181,996	36.00
37.00	Subtotal (see instructions)	6,301,945	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)	6,301,945	40.00
40.01	Sequestration adjustment (see instructions)	126,039	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	6,838,638	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)	-662,732	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:49 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 8:49 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		2,993,212		6,838,638	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,993,212		6,838,638	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		448,783		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		662,732	6.02
7.00	Total Medicare program liability (see instructions)		3,441,995		6,175,906	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: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 8:49 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		1,118,205		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/28/2023	39,400		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)		39,400		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)		1,157,605		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		208,282		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,365,887		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 8:49 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 8:49 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)	1,185,763	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)	214,799	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	458	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)	1,400,562	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,400,562	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)	1,400,562	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,393,762	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)	1,393,762	0	19.00
19.01	Sequestration adjustment (see instructions)	27,875	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	1,157,605	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)	208,282	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 - SWING BEDS | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 8:49 am

Title XIX | Swing Beds - SNF | PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	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)	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		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: 15-1330	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,840,727	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)	3,840,727	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,879,134	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)	3,879,134	19.00
20.00	Deductibles (exclude professional component)	372,580	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,506,554	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,506,554	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,748	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,686	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,748	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,512,240	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)	3,512,240	30.00
30.01	Sequestration adjustment (see instructions)	70,245	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,993,212	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)	448,783	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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 8:49 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	-94,399	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	41,041,746	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,554,179	0	0	0	6.00
7.00	Inventory	484,240	0	0	0	7.00
8.00	Prepaid expenses	1,087,334	0	0	0	8.00
9.00	Other current assets	22,875	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)	13,987,617	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	473,119	0	0	0	12.00
13.00	Land improvements	2,267,188	0	0	0	13.00
14.00	Accumulated depreciation	-1,784,248	0	0	0	14.00
15.00	Buildings	43,411,045	0	0	0	15.00
16.00	Accumulated depreciation	-27,576,735	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	9,955,859	0	0	0	19.00
20.00	Accumulated depreciation	-6,350,988	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	23,524,622	0	0	0	23.00
24.00	Accumulated depreciation	-18,260,415	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	3,759,365	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,418,812	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,434,800	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	9,276,285	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,711,085	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,117,514	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	109,763	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,281,012	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,611,874	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,002,649	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	21,015,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,822,273	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,837,273	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,839,922	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,277,592				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,277,592	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,117,514	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 8:49 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		39,372,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,094,543				2.00
3.00	Total (sum of line 1 and line 2)		31,277,592		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)		31,277,592		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)		31,277,592		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: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2024 8:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,354,156		6,354,156	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	884,663		884,663	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	7,238,819		7,238,819	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,852,214		2,852,214	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)	2,852,214		2,852,214	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,091,033		10,091,033	17.00
18.00	Ancillary services	10,658,398	80,748,150	91,406,548	18.00
19.00	Outpatient services	251,885	17,525,609	17,777,494	19.00
20.00	MONROE FAMILY MEDICINE	0	3,179,905	3,179,905	20.00
20.01	WOODCREST	0	2,198,786	2,198,786	20.01
20.02	STAT CARE	0	2,093,132	2,093,132	20.02
20.03	BERNE FAMILY MEDICINE	0	2,162,034	2,162,034	20.03
20.04	HIGH STREET	0	2,445,984	2,445,984	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	2,185,077	2,185,077	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	0	25,969,134	25,969,134	27.00
27.01	OTHER CLINICS	0	115,598	115,598	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,001,316	138,623,409	159,624,725	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		84,118,924		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		84,118,924		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/29/2024 8:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	159,624,725	1.00
2.00	Less contractual allowances and discounts on patients' accounts	78,886,309	2.00
3.00	Net patient revenues (line 1 minus line 2)	80,738,416	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	84,118,924	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,380,508	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	101,469	6.00
7.00	Income from investments	256,113	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	410,314	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	507,173	17.00
18.00	Revenue from sale of medical records and abstracts	23,862	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	183,331	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	1,515,409	24.00
24.01	CEDIT INCOME	1,904,187	24.01
24.02	FITNESS REVENUE	97,318	24.02
24.03	TRANSPORTATION REVENUE	5,542	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,004,718	25.00
26.00	Total (line 5 plus line 25)	1,624,210	26.00
27.00	BAD DEBTS	9,718,753	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	9,718,753	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,094,543	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 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	676,794	134,168	810,962	0	810,962	1.00
2.00	Physician Assistant	115,271	22,851	138,122	0	138,122	2.00
3.00	Nurse Practitioner	651,258	129,106	780,364	0	780,364	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	374,764	74,294	449,058	0	449,058	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,818,087	360,419	2,178,506	0	2,178,506	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	233,249	233,249	0	233,249	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	233,249	233,249	0	233,249	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,818,087	593,668	2,411,755	0	2,411,755	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	4,069	807	4,876	0	4,876	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)	4,069	807	4,876	0	4,876	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	57,262	57,262	0	57,262	29.00
30.00	Administrative Costs	81,095	73,476	154,571	0	154,571	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	81,095	130,738	211,833	0	211,833	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,903,251	725,213	2,628,464	0	2,628,464	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 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	810,962		1.00
2.00	Physician Assistant	0	138,122		2.00
3.00	Nurse Practitioner	0	780,364		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	449,058		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,178,506		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	233,249		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	233,249		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,411,755		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	4,876		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	4,876		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	57,262		29.00
30.00	Administrative Costs	0	154,571		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	211,833		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,628,464		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 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	494,306	85,741	580,047	0	580,047	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	278,945	48,385	327,330	0	327,330	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	421,886	73,179	495,065	0	495,065	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,195,137	207,305	1,402,442	0	1,402,442	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	235,611	235,611	0	235,611	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	235,611	235,611	0	235,611	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,195,137	442,916	1,638,053	0	1,638,053	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	66	11	77	0	77	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)	66	11	77	0	77	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	72,950	72,950	0	72,950	29.00
30.00	Administrative Costs	43,920	53,202	97,122	0	97,122	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,920	126,152	170,072	0	170,072	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,239,123	569,079	1,808,202	0	1,808,202	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 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	580,047		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	327,330		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	495,065		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,402,442		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	235,611		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	235,611		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,638,053		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	77		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	77		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	72,950		29.00
30.00	Administrative Costs	0	97,122		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	170,072		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,808,202		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330
Component CCN: 15-8537

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

Worksheet M-1
Date/Time Prepared: 5/29/2024 8:49 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	290,435	48,449	338,884	0	338,884	1.00
2.00	Physician Assistant	43,788	7,305	51,093	0	51,093	2.00
3.00	Nurse Practitioner	213,037	35,538	248,575	0	248,575	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	329,724	55,003	384,727	0	384,727	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	45,394	7,572	52,966	0	52,966	9.00
10.00	Subtotal (sum of lines 1 through 9)	922,378	153,867	1,076,245	0	1,076,245	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	113,926	113,926	0	113,926	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	113,926	113,926	0	113,926	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	922,378	267,793	1,190,171	0	1,190,171	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	25,358	25,358	0	25,358	29.00
30.00	Administrative Costs	224,908	178,451	403,359	0	403,359	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	224,908	203,809	428,717	0	428,717	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,147,286	471,602	1,618,888	0	1,618,888	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 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	338,884		1.00
2.00	Physician Assistant	0	51,093		2.00
3.00	Nurse Practitioner	0	248,575		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	384,727		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	52,966		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,076,245		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	113,926		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	113,926		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,190,171		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	25,358		29.00
30.00	Administrative Costs	0	403,359		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	428,717		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,618,888		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	543,292	121,233	664,525	0	664,525	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	252,436	56,330	308,766	0	308,766	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	391,723	87,411	479,134	0	479,134	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,187,451	264,974	1,452,425	0	1,452,425	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	294,798	294,798	0	294,798	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	294,798	294,798	0	294,798	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,187,451	559,772	1,747,223	0	1,747,223	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	217	48	265	0	265	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)	217	48	265	0	265	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	116,343	116,343	0	116,343	29.00
30.00	Administrative Costs	60,004	72,371	132,375	0	132,375	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	60,004	188,714	248,718	0	248,718	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,247,672	748,534	1,996,206	0	1,996,206	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	664,525		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	308,766		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	479,134		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,452,425		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	294,798		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	294,798		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,747,223		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	265		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	265		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-53,859	62,484		29.00
30.00	Administrative Costs	0	132,375		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-53,859	194,859		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,859	1,942,347		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 am

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	467,593	65,761	533,354	0	533,354	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	174,108	24,486	198,594	0	198,594	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	260,271	36,604	296,875	0	296,875	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	901,972	126,851	1,028,823	0	1,028,823	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	168,385	168,385	0	168,385	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168,385	168,385	0	168,385	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	901,972	295,236	1,197,208	0	1,197,208	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	332	47	379	0	379	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)	332	47	379	0	379	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	130,944	130,944	0	130,944	29.00
30.00	Administrative Costs	46,935	45,457	92,392	0	92,392	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	46,935	176,401	223,336	0	223,336	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	949,239	471,684	1,420,923	0	1,420,923	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:49 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	533,354		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	198,594		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	296,875		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,028,823		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	168,385		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168,385		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,197,208		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	379		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	379		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-39,643	91,301		29.00
30.00	Administrative Costs	0	92,392		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-39,643	183,693		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-39,643	1,381,280		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:49 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.39	4,568	4,200	5,838		1.00
2.00	Physician Assistant	0.57	1,784	2,100	1,197		2.00
3.00	Nurse Practitioner	2.90	7,500	2,100	6,090		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.86	13,852		13,125	13,852	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.86	13,852			13,852	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,411,755	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	4,876	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,416,631	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.997982	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	211,833	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	680,679	15.00
16.00	Total overhead (sum of lines 14 and 15)	892,512	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	892,512	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	890,711	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,302,466	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:49 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	1.21	3,453	4,200	5,082		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.12	5,642	2,100	2,352		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.33	9,095		7,434	9,095	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.33	9,095			9,095	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,638,053	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	77	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,638,130	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999953	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	170,072	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	470,678	15.00
16.00	Total overhead (sum of lines 14 and 15)	640,750	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	640,750	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	640,720	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,278,773	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:49 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	0.46	3,489	4,200	1,932		1.00
2.00	Physician Assistant	0.21	1,196	2,100	441		2.00
3.00	Nurse Practitioner	1.15	6,426	2,100	2,415		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.82	11,111		4,788	11,111	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.82	11,111			11,111	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,190,171	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)	1,190,171	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)	428,717	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	594,396	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,023,113	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,023,113	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,023,113	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,213,284	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:49 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.86	3,603	4,200	3,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.12	4,936	2,100	2,352		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.98	8,539		5,964	8,539	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.98	8,539			8,539	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,747,223	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	265	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,747,488	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999848	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	194,859	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	502,896	15.00
16.00	Total overhead (sum of lines 14 and 15)	697,755	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	697,755	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	697,649	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,444,872	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:49 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.76	4,081	4,200	3,192		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.56	3,683	2,100	1,176		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.32	7,764		4,368	7,764	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.32	7,764			7,764	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,197,208	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	379	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,197,587	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999684	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	183,693	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	364,926	15.00
16.00	Total overhead (sum of lines 14 and 15)	548,619	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	548,619	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	548,446	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,745,654	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:49 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)		3,302,466	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		71,434	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,231,032	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,852	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)		13,852	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		233.25	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	305.57	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	233.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,706	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,097,675	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	1,097,675	16.00
16.01	Total program charges (see instructions)(from contractor's records)		852,764	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		30,001	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		38,617	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.)		814,946	16.04
16.05	Total program cost (see instructions)	0	853,563	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,376	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		156,478	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		853,563	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,218	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		865,781	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		865,781	26.00
26.01	Sequestration adjustment (see instructions)		17,316	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		597,488	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)		250,977	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: 15-1330 Component CCN: 15-8536	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:49 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)		2,278,773	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		94,884	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,183,889	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,095	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)		9,095	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		240.12	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	369.33	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	240.12	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,327	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	318,639	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	318,639	16.00
16.01	Total program charges (see instructions)(from contractor's records)		305,699	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,219	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,525	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.)		219,606	16.04
16.05	Total program cost (see instructions)	0	227,131	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,606	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,336	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		227,131	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,971	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		239,102	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		239,102	26.00
26.01	Sequestration adjustment (see instructions)		4,782	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		161,569	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)		72,751	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: 15-1330 Component CCN: 15-8537	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:49 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)			2,213,284	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			292	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,212,992	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,111	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)			11,111	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			199.17	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	182.23		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	182.23		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	692		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	126,103		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	126,103		16.00
16.01	Total program charges (see instructions)(from contractor's records)		104,779		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,960		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,173		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.)		84,366		16.04
16.05	Total program cost (see instructions)	0	91,539		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,472		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,069		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		91,539		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		91,539		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		91,539		26.00
26.01	Sequestration adjustment (see instructions)		1,831		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		72,350		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)		17,358		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: 15-1330 Component CCN: 15-8559	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:49 am
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,444,872	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			94,732	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,350,140	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,539	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)			8,539	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			275.22	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	333.58	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	275.22	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,191	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	327,787	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	327,787	16.00
16.01	Total program charges (see instructions)(from contractor's records)			237,937	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			23,332	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			32,143	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.)			213,379	16.04
16.05	Total program cost (see instructions)		0	245,522	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			28,920	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			37,137	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			245,522	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			6,540	21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			252,062	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			252,062	26.00
26.01	Sequestration adjustment (see instructions)			5,041	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			99,490	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)			147,531	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: 15-1330 Component CCN: 15-8555	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:49 am
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,745,654	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		70,660	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,674,994	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,764	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)		7,764	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.74	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	197.72	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	197.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,900	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	375,668	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	375,668	16.00
16.01	Total program charges (see instructions)(from contractor's records)		331,490	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,810	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,318	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.)		258,510	16.04
16.05	Total program cost (see instructions)	0	262,828	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		48,213	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		55,696	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		262,828	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,270	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		281,098	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		281,098	26.00
26.01	Sequestration adjustment (see instructions)		5,622	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		260,654	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)		14,822	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: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:49 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)	2,178,506	2,178,506	2,178,506	2,178,506	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001380	0.005845	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,006	12,733	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	25,516	10,912	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	28,522	23,645	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,411,755	2,411,755	2,411,755	2,411,755	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	890,711	890,711	890,711	890,711	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011826	0.009804	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,534	8,733	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39,056	32,378	0	0	10.00
11.00	Total number of injections/infusions (from your records)	138	709	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	283.01	45.67	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	23	125	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)	6,509	5,709	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)		71,434	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)		12,218	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:49 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)	1,402,442	1,402,442	1,402,442	1,402,442	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003628	0.010197	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,088	14,301	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	39,690	9,126	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	44,778	23,427	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,638,053	1,638,053	1,638,053	1,638,053	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	640,720	640,720	640,720	640,720	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.027336	0.014302	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,515	9,164	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	62,293	32,591	0	0	10.00
11.00	Total number of injections/infusions (from your records)	211	593	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	295.23	54.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	105	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)	6,200	5,771	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)		94,884	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		11,971	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:49 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)	1,076,245	1,076,245	1,076,245	1,076,245	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000088	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	95	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	62	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	157	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,190,171	1,190,171	1,190,171	1,190,171	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,023,113	1,023,113	1,023,113	1,023,113	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000132	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	135	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	292	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	4	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	73.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	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)		292	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)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,452,425	1,452,425	1,452,425	1,452,425	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003460	0.012646	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,025	18,367	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	34,689	9,619	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	39,714	27,986	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,747,223	1,747,223	1,747,223	1,747,223	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	697,649	697,649	697,649	697,649	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.022730	0.016017	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	15,858	11,174	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	55,572	39,160	0	0	10.00
11.00	Total number of injections/infusions (from your records)	171	625	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	324.98	62.66	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	94	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)	650	5,890	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)		94,732	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)		6,540	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:49 am

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,028,823	1,028,823	1,028,823	1,028,823	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001518	0.024524	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,562	25,231	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,232	12,435	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,794	37,666	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,197,208	1,197,208	1,197,208	1,197,208	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	548,446	548,446	548,446	548,446	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009016	0.031462	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,945	17,255	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15,739	54,921	0	0	10.00
11.00	Total number of injections/infusions (from your records)	50	808	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	314.78	67.97	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	241	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,889	16,381	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		70,660	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)		18,270	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 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		597,488	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)		597,488	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		250,977	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		848,465	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: 15-1330 Component CCN: 15-8536	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 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		161,569	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)		161,569	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		72,751	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		234,320	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: 15-1330 Component CCN: 15-8537	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 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		72,350	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)		72,350	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		17,358	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		89,708	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: 15-1330 Component CCN: 15-8559	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		99,490	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)		99,490	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		147,531	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		247,021	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: 15-1330 Component CCN: 15-8555	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		260,654	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)		260,654	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		14,822	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		275,476	7.00

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