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: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/14/2024 10:45 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/14/2024 Time: 10:45 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 CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Angie Logan		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	Angie Logan			2
3	Signatory Title	CEO			3
4	Date	02/16/2024 11:27:12 AM (PT)			4

Encryption Information
ECR: Date: 2/14/2024 Time: 10:45 am
QAVN8TYZeGTZMPwmc0qrBFDczDkIc0
twMdj0NwkDqxhKaxc6n3:H3pUv3pqT
Qdmw1B29bU0MUQ2b

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
1.00	HOSPITAL	0	492,040	-759,459	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	268,864	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		8,648		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-18,331		0	10.01
10.02	RURAL HEALTH CLINIC III	0		2,944		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		10,320		0	10.03
10.04	RURAL HEALTH CLINIC V	0		3,065		0	10.04
200.00	TOTAL	0	760,904	-752,813	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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/14/2024 10:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	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	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CAMERON URGENT CARE	158545	99915		11/26/2019	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMERON OB/GYN	158546	99915		11/25/2019	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CAMERON NORTH	158570	99915		12/14/2022	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	CAMERON FREMONT	158571	99915		07/18/2023	N	O	O	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)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2024 10:45 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

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/14/2024 10:45 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/14/2024 10:45 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	

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/14/2024 10:45 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	Y	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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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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:	191,474	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		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	06/26/2023	146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/14/2024 10:45 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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/14/2024 10:45 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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/14/2023	Y	11/14/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/14/2024 10:45 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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608.270.2962	DGOODMAN@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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/14/2024 10:45 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	23	8,395	65,528.96	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)		23	8,395	65,528.96	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	1,838.02	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	67,366.98	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/14/2024 10:45 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)	888	78	3,069			1.00
2.00	HMO and other (see instructions)	1,098	0				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	375	0	1,062			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	85			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,263	78	4,216			7.00
8.00	INTENSIVE CARE UNIT	30	3	100			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		35	416			13.00
14.00	Total (see instructions)	1,293	116	4,732	0.00	420.71	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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	RURAL HEALTH CLINIC	1,107	0	8,955	0.00	9.84	26.00
26.01	RURAL HEALTH CLINIC II	1,113	0	19,513	0.00	14.60	26.01
26.02	RURAL HEALTH CLINIC III	124	0	6,399	0.00	10.54	26.02
26.03	RURAL HEALTH CLINIC IV	381	0	6,824	0.00	7.23	26.03
26.04	RURAL HEALTH CLINIC V	4	0	1,301	0.00	1.80	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	464.72	27.00
28.00	Observation Bed Days		0	1,857			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	104			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/14/2024 10:45 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	276	28	1,100	1.00
2.00	HMO and other (see instructions)			285	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	276	28	1,100	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		STEUBEN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	16:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8530

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

Worksheet S-8
Date/Time Prepared:
2/14/2024 10:45 am

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1381 N. WAYNE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	17:30	08:00	19:30	08:00	11.00

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30	08:00	19:30	08:00	19:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8545

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

Worksheet S-8
Date/Time Prepared:
2/14/2024 10:45 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:30	09:00	17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC III | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street				306 E. MAUMEE STREET SUITE 101	1.00
		City			State	ZIP Code
		1.00			2.00	3.00
2.00	City, State, ZIP Code, County	ANGOLA			IN	46703 2.00
						1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
				Grant Award		Date
				1.00		2.00
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
					1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	08:00 11.00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0 13.00
				Provider name		CCN
				1.00		2.00
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
			County			
			4.00			
2.00	City, State, ZIP Code, County					2.00
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3250 INTERTECH DRIVE, STE A		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		STEUBEN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1315 Component CCN: 15-8570	Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 2/14/2024 10:45 am
		RHC IV	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/14/2024 10:45 am

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			401 SOUTH BROAD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FREMONT		IN	46737	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	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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		STEUBEN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8571

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

Worksheet S-8
Date/Time Prepared:
2/14/2024 10:45 am

RHC V | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/14/2024 10:45 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)	0.346201	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,508,553	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	38,375,707	6.00
7.00	Medicaid cost (line 1 times line 6)	13,285,708	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,777,155	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,777,155	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)	303,569	0	303,569	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	105,096	0	105,096	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)	105,096	0	105,096	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)	5,349,232	26.00
27.00	Medicare reimbursable bad debts (see instructions)	336,879	27.00
27.01	Medicare allowable bad debts (see instructions)	518,276	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,830,956	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,853,879	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,958,975	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,736,130	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/14/2024 10:45 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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,566,200	4,566,200	314,772	4,880,972	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,936,333	1,936,333	1,056,554	2,992,887	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	478,261	13,643,999	14,122,260	-1,105,063	13,017,197	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,347,277	9,557,147	16,904,424	42,675	16,947,099	5.00
7.00	00700	OPERATION OF PLANT	1,273,045	3,735,570	5,008,615	0	5,008,615	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,751	29,751	153,079	182,830	8.00
9.00	00900	HOUSEKEEPING	962,583	783,119	1,745,702	-153,079	1,592,623	9.00
10.00	01000	DIETARY	556,733	565,898	1,122,631	-56,132	1,066,499	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	481,975	50,322	532,297	0	532,297	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	326,585	169,109	495,694	0	495,694	14.00
15.00	01500	PHARMACY	490,029	6,229,275	6,719,304	-5,746,507	972,797	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	846,914	405,789	1,252,703	0	1,252,703	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,141,375	1,932,632	6,074,007	-127,852	5,946,155	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	86,036	86,036	31.00
43.00	04300	NURSERY	0	0	0	15,011	15,011	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,864,143	1,686,816	3,550,959	-887,513	2,663,446	50.00
51.00	05100	RECOVERY ROOM	0	0	0	887,513	887,513	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,371	5,853	76,224	26,805	103,029	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,374,489	1,280,532	3,655,021	0	3,655,021	54.00
60.00	06000	LABORATORY	1,086,490	2,805,406	3,891,896	0	3,891,896	60.00
65.00	06500	RESPIRATORY THERAPY	1,046,708	464,887	1,511,595	-209,652	1,301,943	65.00
65.01	06501	SLEEP LAB	0	0	0	84,416	84,416	65.01
66.00	06600	PHYSICAL THERAPY	1,468,200	34,345	1,502,545	0	1,502,545	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,552	7,552	125,236	132,788	69.00
69.01	06901	CARDIAC REHABILITATION	81,631	12,734	94,365	0	94,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,956,309	2,956,309	-1,908,354	1,047,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,908,354	1,908,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,194,584	3,194,584	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	2,243,615	2,243,615	0	2,243,615	76.01
76.02	03030	DIABETIC EDUCATION	0	83,246	83,246	0	83,246	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,076,324	145,048	1,221,372	137,416	1,358,788	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,545,929	304,720	1,850,649	245,282	2,095,931	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,169,277	407,077	1,576,354	176,819	1,753,173	88.02
88.03	08803	RURAL HEALTH CLINIC IV	930,797	113,570	1,044,367	-113,698	930,669	88.03
88.04	08804	RURAL HEALTH CLINIC V	985,168	95,340	1,080,508	-831,018	249,490	88.04
90.00	09000	CLINIC	108,067	17,641	125,708	0	125,708	90.00
90.01	09001	CLINIC- ORTHO	877,617	1,273,961	2,151,578	82,072	2,233,650	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,049,517	59,463	1,108,980	226,737	1,335,717	90.02
90.03	09003	INTRAVENOUS THERAPY	92,384	15,226	107,610	2,497,827	2,605,437	90.03
90.04	09004	PSYCHIATRY	412,498	283,747	696,245	89,151	785,396	90.04
90.05	09005	CARDIOLOGY	1,203,400	99,184	1,302,584	86,455	1,389,039	90.05
91.00	09100	EMERGENCY	2,315,266	500,263	2,815,529	0	2,815,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,293,978	1,293,978	-1,293,978	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,663,053	59,795,657	96,458,710	-996,052	95,462,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	66,537	55,413	121,950	-57,662	64,288	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	222,746	923,944	1,146,690	-193,063	953,627	194.05
194.06	07956	GUEST MEALS	0	0	0	56,132	56,132	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	137,301	8,727	146,028	0	146,028	194.12

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/14/2024 10:45 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	
194.13	07963	OCCUPATIONAL HEALTH	346,514	123,402	469,916	21,040	490,956	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132,585	236,132	368,717	1,882	370,599	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	245,377	245,377	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	97,381	17,793	115,174	922,346	1,037,520	194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	37,666,117	61,161,068	98,827,185	0	98,827,185	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,289,800	3,591,172		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-118,198	2,874,689		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-280,171	12,737,026		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,374,818	12,572,281		5.00
7.00	00700	OPERATION OF PLANT	0	5,008,615		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	182,830		8.00
9.00	00900	HOUSEKEEPING	0	1,592,623		9.00
10.00	01000	DIETARY	-310,158	756,341		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	532,297		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,300	492,394		14.00
15.00	01500	PHARMACY	-14,253	958,544		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-620	1,252,083		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-878,797	5,067,358		30.00
31.00	03100	INTENSIVE CARE UNIT	0	86,036		31.00
43.00	04300	NURSERY	0	15,011		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-661,261	2,002,185		50.00
51.00	05100	RECOVERY ROOM	0	887,513		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	103,029		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,750	3,647,271		54.00
60.00	06000	LABORATORY	-6,126	3,885,770		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,301,943		65.00
65.01	06501	SLEEP LAB	0	84,416		65.01
66.00	06600	PHYSICAL THERAPY	-1,250	1,501,295		66.00
69.00	06900	ELECTROCARDIOLOGY	0	132,788		69.00
69.01	06901	CARDIAC REHABILITATION	-1,367	92,998		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,047,955		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,908,354		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,194,584		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	-32,168	2,211,447		76.01
76.02	03030	DIABETIC EDUCATION	0	83,246		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,358,788		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,095,931		88.01
88.02	08802	RURAL HEALTH CLINIC III	-72,744	1,680,429		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-38,845	891,824		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	249,490		88.04
90.00	09000	CLINIC	0	125,708		90.00
90.01	09001	CLINIC- ORTHO	-1,722,427	511,223		90.01
90.02	09002	CLINIC - PEDS ENT FP	-646,301	689,416		90.02
90.03	09003	INTRAVENOUS THERAPY	0	2,605,437		90.03
90.04	09004	PSYCHIATRY	-531,232	254,164		90.04
90.05	09005	CARDIOLOGY	-724,279	664,760		90.05
91.00	09100	EMERGENCY	0	2,815,529		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,715,865	83,746,793		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	64,288		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	0		194.04
194.05	07955	MARKETING	0	953,627		194.05
194.06	07956	GUEST MEALS	0	56,132		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	0		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	146,028		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	490,956		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0		194.14

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.15	07965	FOUNDATION	0	370,599		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	245,377		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	1,037,520		194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,715,865	87,111,320		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/14/2024 10:45 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	12,622	2,389	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	22,539	4,266	2.00
	TOTALS		35,161	6,655	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	25,878	2.00
	TOTALS		0	92,556	
	C - CAFETERIA				
1.00	GUEST MEALS	194.06	27,837	28,295	1.00
	TOTALS		27,837	28,295	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,289,800	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,178	2.00
	TOTALS		0	1,293,978	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,026,498	1.00
	TOTALS		0	1,026,498	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	65,712	20,324	1.00
	TOTALS		65,712	20,324	
	H - SLEEP LAB - EKG				
1.00	SLEEP LAB	65.01	38,599	45,817	1.00
2.00	ELECTROCARDIOLOGY	69.00	19,610	15,656	2.00
	TOTALS		58,209	61,473	
	I - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	13,363	1.00
	TOTALS		0	13,363	
	J - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	887,513	0	1.00
	TOTALS		887,513	0	
	K - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,908,354	1.00
	TOTALS		0	1,908,354	
	L - FOUNDATION RECLASS				
1.00	FOUNDATION	194.15	1,882	0	1.00
	TOTALS		1,882	0	
	M - IMMUNIZATION CLINIC RECLASS				
1.00	CLINIC - PEDS ENT FP	90.02	0	54,096	1.00
	TOTALS		0	54,096	
	N - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,692,411	1.00
	TOTALS		0	5,692,411	
	O - IV THERAPY				
1.00	INTRAVENOUS THERAPY	90.03	0	2,497,827	1.00
	TOTALS		0	2,497,827	
	P - EKG HST RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	89,970	0	1.00
	TOTALS		89,970	0	
	Q - OFFSITE DEPRECIATION				
1.00	CAMERON FAMILY MEDICINE - NORTH	194.16	0	1,092	1.00
2.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	0	8,663	2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	4,144	3.00
4.00	RURAL HEALTH CLINIC V	88.04	0	1,309	4.00
	TOTALS		0	15,208	
	R - PROVIDER BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	137,416	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	245,282	2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	176,819	3.00
4.00	CLINIC- ORTHO	90.01	0	82,072	4.00
5.00	CLINIC - PEDS ENT FP	90.02	0	156,691	5.00
6.00	PSYCHIATRY	90.04	0	49,151	6.00
7.00	CARDIOLOGY	90.05	0	86,455	7.00
8.00	OCCUPATIONAL HEALTH	194.13	0	21,040	8.00
9.00	CAMERON FAMILY MEDICINE - NORTH	194.16	0	26,382	9.00
10.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	0	63,978	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	100,061	11.00
12.00	RURAL HEALTH CLINIC V	88.04	0	17,378	12.00
	TOTALS		0	1,162,725	

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/14/2024 10:45 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	T - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	153,079		1.00
	TOTALS		0	153,079		
	U - NON RHC RECLASS					
1.00	CAMERON FAMILY MEDICINE - NORTH	194.16	194,207	23,696		1.00
2.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	774,730	74,975		2.00
	TOTALS		968,937	98,671		
	V - ALLOWABLE MARKETING COST RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	26,884	123,592		1.00
2.00	CLINIC - PEDS ENT FP	90.02	0	15,950		2.00
3.00	PSYCHIATRY	90.04	0	40,000		3.00
	TOTALS		26,884	179,542		
	W - EMPLOYEE WELLNESS COST RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	29,956	27,706		1.00
	TOTALS		29,956	27,706		
500.00	Grand Total: Increases		2,192,061	14,332,761		500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/14/2024 10:45 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	35,161	6,655	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		35,161	6,655		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,556	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	92,556		
	C - CAFETERIA					
1.00	DIETARY	10.00	27,837	28,295	0	1.00
	TOTALS		27,837	28,295		
	D - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,293,978	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	1,293,978		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,026,498	9	1.00
	TOTALS		0	1,026,498		
	F - ICU					
1.00	ADULTS & PEDIATRICS	30.00	65,712	20,324	0	1.00
	TOTALS		65,712	20,324		
	H - SLEEP LAB - EKG					
1.00	RESPIRATORY THERAPY	65.00	58,209	61,473	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		58,209	61,473		
	I - PUBLIC RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,363	0	1.00
	TOTALS		0	13,363		
	J - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	887,513	0	0	1.00
	TOTALS		887,513	0		
	K - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,908,354	0	1.00
	TOTALS		0	1,908,354		
	L - FOUNDATION RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,882	0	0	1.00
	TOTALS		1,882	0		
	M - IMMUNIZATION CLINIC RECLASS					
1.00	PHARMACY	15.00	0	54,096	0	1.00
	TOTALS		0	54,096		
	N - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	5,692,411	0	1.00
	TOTALS		0	5,692,411		
	O - IV THERAPY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,497,827	0	1.00
	TOTALS		0	2,497,827		
	P - EKG HST RECLASS					
1.00	RESPIRATORY THERAPY	65.00	89,970	0	0	1.00
	TOTALS		89,970	0		
	Q - OFFSITE DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,208	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	15,208		
	R - PROVIDER BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,162,725	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
	TOTALS		0	1,162,725		
	T - LAUNDRY RECLASS					
1.00	HOUSEKEEPING	9.00	0	153,079	0	1.00
	TOTALS		0	153,079		

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/14/2024 10:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	U - NON RHC RECLASS						
1.00	RURAL HEALTH CLINIC IV	88.03	194,207	23,696	0		1.00
2.00	RURAL HEALTH CLINIC V	88.04	774,730	74,975	0		2.00
	TOTALS		968,937	98,671			
	V - ALLOWABLE MARKETING COST RECLASS						
1.00	MARKETING	194.05	26,884	123,592	0		1.00
2.00	MARKETING	194.05	0	15,950	0		2.00
3.00	MARKETING	194.05	0	40,000	0		3.00
	TOTALS		26,884	179,542			
	W - EMPLOYEE WELLNESS COST RECLASS						
1.00	COMMUNITY HEALTH	194.02	29,956	27,706	0		1.00
	TOTALS		29,956	27,706			
500.00	Grand Total: Decreases		2,192,061	14,332,761			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/14/2024 10:45 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	2,019,703	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	61,152,127	284,903	0	284,903	55,578	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,762,922	1,465,317	0	1,465,317	21,891	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	82,934,752	1,750,220	0	1,750,220	77,469	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	82,934,752	1,750,220	0	1,750,220	77,469	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,019,703	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	61,381,452	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,206,348	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	84,607,503	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	84,607,503	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/14/2024 10:45 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,566,200	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,936,333	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,566,200	1,936,333	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,566,200	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,936,333	2.00
3.00	Total (sum of lines 1-2)	0	6,502,533	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/14/2024 10:45 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,381,452	0	61,381,452	0.743227	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,206,348	0	21,206,348	0.256773	0	2.00
3.00	Total (sum of lines 1-2)	82,587,800	0	82,587,800	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,524,494	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	912,478	1,936,333	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,436,972	1,936,333	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	66,678	0	0	3,591,172	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	25,878	0	0	2,874,689	2.00
3.00	Total (sum of lines 1-2)	0	92,556	0	0	6,465,861	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/14/2024 10:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-1,289,800	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-4,178	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	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)	B	-10,634	ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,122,223			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	-427,791			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-289,995	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	-14,253	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-620	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	B	-4,683	DIETARY	10.00	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	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-6,091	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/14/2024 10:45 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	
33.01	MEALS ON WHEELS	B	-15,480	DIETARY	10.00	0	33.01
33.02	RENTAL INCOME OFFSET - CANCER CENTER	B	-32,168	ONCOLOGY	76.01	0	33.02
33.03	ATM SURCHARGE REVENUE	B	-177	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RHC OB PHYSICIAN & MIDLEVELS OFFSET	A	-72,744	RURAL HEALTH CLINIC III	88.02	0	33.04
33.05	MEDICAID HAF EXPENSE	A	-4,277,063	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PHYSICIAN RECRUITMENT	A	-356	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC REVENUE	B	-47,191	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER PHYSICIAL THERAPY REVENUE	B	-1,250	PHYSICAL THERAPY	66.00	0	33.08
33.09	CARDIAC REHAB FITNESS REVENUE	B	-1,367	CARDIAC REHABILITATION	69.01	0	33.09
33.10	ALCOHOL EXPENSE	A	-3,006	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NORTH RHC RENTAL REVENUE	B	-38,845	RURAL HEALTH CLINIC IV	88.03	0	33.11
33.12	GI PROVIDER RECRUITMENT FEES	A	-15,950	CLINIC - PEDS ENT FP	90.02	0	33.12
33.13	PSYCH PROVIDER RECRUITMENT FEES	A	-40,000	PSYCHIATRY	90.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,715,865				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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/14/2024 10:45 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	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	891,635	1,005,655	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	232,796	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	26,850	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	CMO EXPENSE - CAMERON WOODS	0	3,300	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	3,450	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - RETAIL PHARMAC	0	47,375	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			891,635	1,319,426	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	C	CAMERON MEDICAL	100.00		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: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/14/2024 10:45 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	-114,020	9		1.00
2.00	-232,796	0		2.00
3.00	-26,850	0		3.00
3.01	-3,300	0		3.01
4.00	-3,450	0		4.00
4.01	-47,375	0		4.01
5.00	-427,791			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			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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/14/2024 10:45 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	878,797	878,797	0	0	0	1.00
2.00	50.00	OPERATING ROOM	661,261	661,261	0	0	0	2.00
3.00	60.00	LABORATORY	18,563	6,126	12,437	0	0	3.00
4.00	90.01	CLINIC- ORTHO	1,722,427	1,722,427	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP	630,351	630,351	0	0	0	5.00
6.00	90.04	PSYCHIATRY	491,232	491,232	0	0	0	6.00
7.00	90.05	CARDIOLOGY	724,279	724,279	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	7,750	7,750	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,134,660	5,122,223	12,437		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP	0	0	0	0	0	5.00
6.00	90.04	PSYCHIATRY	0	0	0	0	0	6.00
7.00	90.05	CARDIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	878,797		1.00
2.00	50.00	OPERATING ROOM	0	0	0	661,261		2.00
3.00	60.00	LABORATORY	0	0	0	6,126		3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	1,722,427		4.00
5.00	90.02	CLINIC - PEDS ENT FP	0	0	0	630,351		5.00
6.00	90.04	PSYCHIATRY	0	0	0	491,232		6.00
7.00	90.05	CARDIOLOGY	0	0	0	724,279		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,750		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,122,223		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,591,172	3,591,172				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,874,689		2,874,689			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,737,026	29,415	19,707	12,786,148		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,572,281	298,516	257,696	3,037,070	16,165,563	5.00
7.00	00700	OPERATION OF PLANT	5,008,615	352,630	184,874	524,444	6,070,563	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	182,830	37,101	19,451	0	239,382	8.00
9.00	00900	HOUSEKEEPING	1,592,623	6,288	3,297	396,546	1,998,754	9.00
10.00	01000	DIETARY	756,341	207,477	108,774	217,884	1,290,476	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	532,297	23,057	32,015	198,554	785,923	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	492,394	108,856	57,070	134,540	792,860	14.00
15.00	01500	PHARMACY	958,544	40,349	21,154	201,872	1,221,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,252,083	0	20,275	348,895	1,621,253	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,067,358	652,298	341,983	1,664,525	7,726,164	30.00
31.00	03100	INTENSIVE CARE UNIT	86,036	41,223	21,612	27,071	175,942	31.00
43.00	04300	NURSERY	15,011	14,673	7,692	5,200	42,576	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,002,185	383,652	201,138	402,332	2,989,307	50.00
51.00	05100	RECOVERY ROOM	887,513	248,280	130,167	365,620	1,631,580	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,029	61,310	32,143	38,275	234,757	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,647,271	293,765	154,013	978,194	5,073,243	54.00
60.00	06000	LABORATORY	3,885,770	96,909	50,807	447,590	4,481,076	60.00
65.00	06500	RESPIRATORY THERAPY	1,301,943	25,502	13,370	370,158	1,710,973	65.00
65.01	06501	SLEEP LAB	84,416	0	47,620	15,901	147,937	65.01
66.00	06600	PHYSICAL THERAPY	1,501,295	220,507	115,606	604,840	2,442,248	66.00
69.00	06900	ELECTROCARDIOLOGY	132,788	13,170	6,905	45,142	198,005	69.00
69.01	06901	CARDIAC REHABILITATION	92,998	22,009	11,539	33,629	160,175	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,955	0	0	0	1,047,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,908,354	0	0	0	1,908,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,194,584	0	0	0	3,194,584	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	2,211,447	0	203,299	0	2,414,746	76.01
76.02	03030	DIABETIC EDUCATION	83,246	0	0	0	83,246	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,358,788	0	124,342	150,135	1,633,265	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,095,931	0	119,580	213,009	2,428,520	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,680,429	0	64,030	58,195	1,802,654	88.02
88.03	08803	RURAL HEALTH CLINIC IV	891,824	0	0	87,579	979,403	88.03
88.04	08804	RURAL HEALTH CLINIC V	249,490	0	0	49,169	298,659	88.04
90.00	09000	CLINIC	125,708	13,974	15,220	44,519	199,421	90.00
90.01	09001	CLINIC- ORTHO	511,223	0	72,821	191,464	775,508	90.01
90.02	09002	CLINIC - PEDS ENT FP	689,416	0	109,525	168,174	967,115	90.02
90.03	09003	INTRAVENOUS THERAPY	2,605,437	41,922	21,978	38,059	2,707,396	90.03
90.04	09004	PSYCHIATRY	254,164	0	32,363	47,698	334,225	90.04
90.05	09005	CARDIOLOGY	664,760	0	26,960	160,835	852,555	90.05
91.00	09100	EMERGENCY	2,815,529	333,416	174,801	953,797	4,277,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,746,793	3,566,299	2,823,827	12,220,915	83,105,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	20,262	10,623	0	30,885	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,850	0	1,850	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	64,288	0	0	15,070	79,358	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	953,627	0	18,627	80,687	1,052,941	194.05
194.06	07956	GUEST MEALS	56,132	0	0	11,468	67,600	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	146,028	0	0	56,563	202,591	194.12
194.13	07963	OCCUPATIONAL HEALTH	490,956	0	15,513	101,812	608,281	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	370,599	4,611	4,249	55,395	434,854	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	245,377	0	0	23,107	268,484	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	1,037,520	0	0	221,131	1,258,651	194.17
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)	87,111,320	3,591,172	2,874,689	12,786,148	87,111,320	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/14/2024 10:45 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,165,563					5.00
7.00	00700	OPERATION OF PLANT	1,383,226	7,453,789				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,545	95,011	388,938			8.00
9.00	00900	HOUSEKEEPING	455,432	16,104	0	2,470,290		9.00
10.00	01000	DIETARY	294,045	531,327	0	41,086	2,156,934	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	179,079	59,046	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	180,659	278,770	0	14,222	0	14.00
15.00	01500	PHARMACY	278,424	103,331	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,415	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,760,473	1,670,475	352,909	600,884	2,121,993	30.00
31.00	03100	INTENSIVE CARE UNIT	40,090	105,568	5,811	1,185	34,941	31.00
43.00	04300	NURSERY	9,701	37,575	24,174	167,504	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	681,138	982,494	0	280,490	0	50.00
51.00	05100	RECOVERY ROOM	371,769	635,821	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,491	157,009	6,044	2,370	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,155,979	752,303	0	161,973	0	54.00
60.00	06000	LABORATORY	1,021,049	248,173	0	76,641	0	60.00
65.00	06500	RESPIRATORY THERAPY	389,859	65,309	0	19,358	0	65.00
65.01	06501	SLEEP LAB	33,709	0	0	21,728	0	65.01
66.00	06600	PHYSICAL THERAPY	556,486	564,697	0	93,628	0	66.00
69.00	06900	ELECTROCARDIOLOGY	45,117	33,728	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	36,497	56,362	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,785	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	434,834	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	727,912	0	0	37,925	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	550,219	0	0	83,752	0	76.01
76.02	03030	DIABETIC EDUCATION	18,968	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	372,152	0	0	64,789	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	553,358	0	0	128,393	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	410,749	0	0	28,839	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	223,165	0	0	69,135	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	68,052	0	0	17,778	0	88.04
90.00	09000	CLINIC	45,440	35,786	0	21,728	0	90.00
90.01	09001	CLINIC- ORTHO	176,706	0	0	75,456	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	220,365	0	0	60,444	0	90.02
90.03	09003	INTRAVENOUS THERAPY	616,902	107,357	0	0	0	90.03
90.04	09004	PSYCHIATRY	76,156	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	194,261	0	0	43,456	0	90.05
91.00	09100	EMERGENCY	974,672	853,845	0	294,317	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,252,879	7,390,091	388,938	2,407,081	2,156,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7,037	51,889	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	422	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	18,082	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	239,921	0	0	0	0	194.05
194.06	07956	GUEST MEALS	15,403	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	46,162	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	138,602	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.15	07965	FOUNDATION	99,085	11,809	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	61,176	0	0	9,876	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	286,794	0	0	53,333	0	194.17
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)	16,165,563	7,453,789	388,938	2,470,290	2,156,934	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,024,048				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,266,511			14.00
15.00	01500	PHARMACY	0	0	8,131	1,611,805		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,122	0	1,992,790	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	340,795	92,611	0	125,490	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,690	0	0	2,696	31.00
43.00	04300	NURSERY	0	0	0	0	3,762	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	85,564	181,438	0	137,316	50.00
51.00	05100	RECOVERY ROOM	0	66,896	0	0	62,714	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,204	0	0	11,889	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	39,027	0	471,996	54.00
60.00	06000	LABORATORY	0	0	1,182	0	274,731	60.00
65.00	06500	RESPIRATORY THERAPY	0	89,334	12,853	0	26,784	65.00
65.01	06501	SLEEP LAB	0	0	0	0	11,599	65.01
66.00	06600	PHYSICAL THERAPY	0	141,175	5,183	0	63,359	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,460	1,576	0	30,225	69.00
69.01	06901	CARDIAC REHABILITATION	0	10,599	468	0	6,044	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	694,165	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	904,545	21,859	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	217,594	76.01
76.02	03030	DIABETIC EDUCATION	0	0	44	0	556	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	14,054	0	20,671	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	78,223	0	40,765	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	5,967	0	21,345	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	9,869	0	17,297	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	2,006	0	2,932	88.04
90.00	09000	CLINIC	0	8,991	6,345	0	5,374	90.00
90.01	09001	CLINIC- ORTHO	0	0	7,132	0	3,616	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	7,405	0	7,713	90.02
90.03	09003	INTRAVENOUS THERAPY	0	8,019	4,696	707,260	80,777	90.03
90.04	09004	PSYCHIATRY	0	0	254	0	2,406	90.04
90.05	09005	CARDIOLOGY	0	42,800	776	0	24,343	90.05
91.00	09100	EMERGENCY	0	212,521	75,376	0	280,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,024,048	1,251,577	1,611,805	1,976,085	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	2	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	20	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	2,802	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	1,605	0	0	194.13

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	517	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	2,601	0	4,564	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	7,387	0	12,141	194.17
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	1,024,048	1,266,511	1,611,805	1,992,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,791,794	0	14,791,794		30.00
31.00	03100	INTENSIVE CARE UNIT	372,923	0	372,923		31.00
43.00	04300	NURSERY	285,292	0	285,292		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,337,747	0	5,337,747		50.00
51.00	05100	RECOVERY ROOM	2,768,780	0	2,768,780		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,764	0	471,764		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,654,521	0	7,654,521		54.00
60.00	06000	LABORATORY	6,102,852	0	6,102,852		60.00
65.00	06500	RESPIRATORY THERAPY	2,314,470	0	2,314,470		65.00
65.01	06501	SLEEP LAB	214,973	0	214,973		65.01
66.00	06600	PHYSICAL THERAPY	3,866,776	0	3,866,776		66.00
69.00	06900	ELECTROCARDIOLOGY	313,111	0	313,111		69.00
69.01	06901	CARDIAC REHABILITATION	270,145	0	270,145		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,287,414	0	1,287,414		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,037,353	0	3,037,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,825	0	4,886,825		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	3,266,311	0	3,266,311		76.01
76.02	03030	DIABETIC EDUCATION	102,814	0	102,814		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,104,931	0	2,104,931		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,229,259	0	3,229,259		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,269,554	0	2,269,554		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,298,869	0	1,298,869		88.03
88.04	08804	RURAL HEALTH CLINIC V	389,427	0	389,427		88.04
90.00	09000	CLINIC	323,085	0	323,085		90.00
90.01	09001	CLINIC- ORTHO	1,038,418	0	1,038,418		90.01
90.02	09002	CLINIC - PEDS ENT FP	1,263,042	0	1,263,042		90.02
90.03	09003	INTRAVENOUS THERAPY	4,232,407	0	4,232,407		90.03
90.04	09004	PSYCHIATRY	413,041	0	413,041		90.04
90.05	09005	CARDIOLOGY	1,158,191	0	1,158,191		90.05
91.00	09100	EMERGENCY	6,968,506	0	6,968,506		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,034,595	0	82,034,595		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	89,811	0	89,811		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,272	0	2,272		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	97,442	0	97,442		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	1,292,882	0	1,292,882		194.05
194.06	07956	GUEST MEALS	83,003	0	83,003		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.12	07962	TRINE STUDENT HEALTH	251,555	0	251,555		194.12
194.13	07963	OCCUPATIONAL HEALTH	748,488	0	748,488		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	546,265	0	546,265		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	346,701	0	346,701		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	1,618,306	0	1,618,306		194.17
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)	87,111,320	0	87,111,320		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	29,415	19,707	49,122	49,122	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	298,516	257,696	556,212	11,660	5.00
7.00	00700	OPERATION OF PLANT	0	352,630	184,874	537,504	2,015	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,101	19,451	56,552	0	8.00
9.00	00900	HOUSEKEEPING	0	6,288	3,297	9,585	1,524	9.00
10.00	01000	DIETARY	0	207,477	108,774	316,251	837	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,057	32,015	55,072	763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	108,856	57,070	165,926	517	14.00
15.00	01500	PHARMACY	0	40,349	21,154	61,503	776	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	20,275	20,275	1,341	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	652,298	341,983	994,281	6,396	30.00
31.00	03100	INTENSIVE CARE UNIT	0	41,223	21,612	62,835	104	31.00
43.00	04300	NURSERY	0	14,673	7,692	22,365	20	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	383,652	201,138	584,790	1,546	50.00
51.00	05100	RECOVERY ROOM	0	248,280	130,167	378,447	1,405	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	61,310	32,143	93,453	147	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	293,765	154,013	447,778	3,759	54.00
60.00	06000	LABORATORY	0	96,909	50,807	147,716	1,720	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,502	13,370	38,872	1,422	65.00
65.01	06501	SLEEP LAB	0	0	47,620	47,620	61	65.01
66.00	06600	PHYSICAL THERAPY	0	220,507	115,606	336,113	2,324	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,170	6,905	20,075	173	69.00
69.01	06901	CARDIAC REHABILITATION	0	22,009	11,539	33,548	129	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	203,299	203,299	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	124,342	124,342	577	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	119,580	119,580	819	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	64,030	64,030	224	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	337	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	189	88.04
90.00	09000	CLINIC	0	13,974	15,220	29,194	171	90.00
90.01	09001	CLINIC- ORTHO	0	0	72,821	72,821	736	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	109,525	109,525	646	90.02
90.03	09003	INTRAVENOUS THERAPY	0	41,922	21,978	63,900	146	90.03
90.04	09004	PSYCHIATRY	0	0	32,363	32,363	183	90.04
90.05	09005	CARDIOLOGY	0	0	26,960	26,960	618	90.05
91.00	09100	EMERGENCY	0	333,416	174,801	508,217	3,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,566,299	2,823,827	6,390,126	46,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	20,262	10,623	30,885	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,850	1,850	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	58	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	18,627	18,627	310	194.05
194.06	07956	GUEST MEALS	0	0	0	0	44	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	217	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	15,513	15,513	391	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	4,611	4,249	8,860	213	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	89	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	850	194.17
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	3,591,172	2,874,689	6,465,861	49,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/14/2024 10:45 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	567,872					5.00
7.00	00700	OPERATION OF PLANT	48,589	588,108				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,916	7,496	65,964			8.00
9.00	00900	HOUSEKEEPING	15,998	1,271	0	28,378		9.00
10.00	01000	DIETARY	10,329	41,922	0	472	369,811	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,291	4,659	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,346	21,995	0	163	0	14.00
15.00	01500	PHARMACY	9,780	8,153	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,977	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,862	131,800	59,853	6,904	363,820	30.00
31.00	03100	INTENSIVE CARE UNIT	1,408	8,329	986	14	5,991	31.00
43.00	04300	NURSERY	341	2,965	4,100	1,924	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,926	77,519	0	3,222	0	50.00
51.00	05100	RECOVERY ROOM	13,059	50,167	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,879	12,388	1,025	27	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,606	59,357	0	1,861	0	54.00
60.00	06000	LABORATORY	35,867	19,581	0	880	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,695	5,153	0	222	0	65.00
65.01	06501	SLEEP LAB	1,184	0	0	250	0	65.01
66.00	06600	PHYSICAL THERAPY	19,548	44,555	0	1,076	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,585	2,661	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,282	4,447	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,388	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,274	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,569	0	0	436	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	19,328	0	0	962	0	76.01
76.02	03030	DIABETIC EDUCATION	666	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,073	0	0	744	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	19,438	0	0	1,475	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	14,428	0	0	331	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	7,839	0	0	794	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,390	0	0	204	0	88.04
90.00	09000	CLINIC	1,596	2,824	0	250	0	90.00
90.01	09001	CLINIC- ORTHO	6,207	0	0	867	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	7,741	0	0	694	0	90.02
90.03	09003	INTRAVENOUS THERAPY	21,670	8,471	0	0	0	90.03
90.04	09004	PSYCHIATRY	2,675	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	6,824	0	0	499	0	90.05
91.00	09100	EMERGENCY	34,237	67,369	0	3,381	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	535,811	583,082	65,964	27,652	369,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	247	4,094	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	15	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	635	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	8,428	0	0	0	0	194.05
194.06	07956	GUEST MEALS	541	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	1,622	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	4,869	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.15	07965	FOUNDATION	3,481	932	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	2,149	0	0	113	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	10,074	0	0	613	0	194.17
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)	567,872	588,108	65,964	28,378	369,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	66,785				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	194,947			14.00
15.00	01500	PHARMACY	0	0	1,251	81,463		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	327	0	34,920	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	22,226	14,255	0	2,194	30.00
31.00	03100	INTENSIVE CARE UNIT	0	436	0	0	47	31.00
43.00	04300	NURSERY	0	0	0	0	66	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,580	27,928	0	2,401	50.00
51.00	05100	RECOVERY ROOM	0	4,363	0	0	1,096	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	405	0	0	208	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,007	0	8,333	54.00
60.00	06000	LABORATORY	0	0	182	0	4,803	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,826	1,978	0	468	65.00
65.01	06501	SLEEP LAB	0	0	0	0	203	65.01
66.00	06600	PHYSICAL THERAPY	0	9,207	798	0	1,108	66.00
69.00	06900	ELECTROCARDIOLOGY	0	291	243	0	528	69.00
69.01	06901	CARDIAC REHABILITATION	0	691	72	0	106	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	104	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	106,850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	45,717	382	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	3,804	76.01
76.02	03030	DIABETIC EDUCATION	0	0	7	0	10	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,163	0	361	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	12,040	0	713	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	918	0	373	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,519	0	302	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	309	0	51	88.04
90.00	09000	CLINIC	0	586	977	0	94	90.00
90.01	09001	CLINIC- ORTHO	0	0	1,098	0	63	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	1,140	0	135	90.02
90.03	09003	INTRAVENOUS THERAPY	0	523	723	35,746	1,412	90.03
90.04	09004	PSYCHIATRY	0	0	39	0	42	90.04
90.05	09005	CARDIOLOGY	0	2,791	119	0	426	90.05
91.00	09100	EMERGENCY	0	13,860	11,602	0	4,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	66,785	192,649	81,463	34,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	3	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	431	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	247	0	0	194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	80	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	400	0	80	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	1,137	0	212	194.17
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	66,785	194,947	81,463	34,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,663,591	0	1,663,591		30.00
31.00	03100	INTENSIVE CARE UNIT	80,150	0	80,150		31.00
43.00	04300	NURSERY	31,781	0	31,781		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	726,912	0	726,912		50.00
51.00	05100	RECOVERY ROOM	448,537	0	448,537		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,532	0	109,532		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,701	0	567,701		54.00
60.00	06000	LABORATORY	210,749	0	210,749		60.00
65.00	06500	RESPIRATORY THERAPY	67,636	0	67,636		65.00
65.01	06501	SLEEP LAB	49,318	0	49,318		65.01
66.00	06600	PHYSICAL THERAPY	414,729	0	414,729		66.00
69.00	06900	ELECTROCARDIOLOGY	25,556	0	25,556		69.00
69.01	06901	CARDIAC REHABILITATION	40,275	0	40,275		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,492	0	8,492		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,124	0	122,124		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,104	0	72,104		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	227,393	0	227,393		76.01
76.02	03030	DIABETIC EDUCATION	683	0	683		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	141,260	0	141,260		88.00
88.01	08801	RURAL HEALTH CLINIC II	154,065	0	154,065		88.01
88.02	08802	RURAL HEALTH CLINIC III	80,304	0	80,304		88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,791	0	10,791		88.03
88.04	08804	RURAL HEALTH CLINIC V	3,143	0	3,143		88.04
90.00	09000	CLINIC	35,692	0	35,692		90.00
90.01	09001	CLINIC- ORTHO	81,792	0	81,792		90.01
90.02	09002	CLINIC - PEDS ENT FP	119,881	0	119,881		90.02
90.03	09003	INTRAVENOUS THERAPY	132,591	0	132,591		90.03
90.04	09004	PSYCHIATRY	35,302	0	35,302		90.04
90.05	09005	CARDIOLOGY	38,237	0	38,237		90.05
91.00	09100	EMERGENCY	647,230	0	647,230		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,347,551	0	6,347,551		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	35,226	0	35,226		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,865	0	1,865		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	693	0	693		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	27,368	0	27,368		194.05
194.06	07956	GUEST MEALS	585	0	585		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.12	07962	TRINE STUDENT HEALTH	2,270	0	2,270		194.12
194.13	07963	OCCUPATIONAL HEALTH	21,020	0	21,020		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	13,566	0	13,566		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	2,831	0	2,831		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	12,886	0	12,886		194.17
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)	6,465,861	0	6,465,861		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	CAP REL COSTS-BLDG & FIXT	102,797					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		156,956				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842	1,076	31,037,390			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,545	14,070	7,372,279	-16,165,563	70,945,757	5.00
7.00	00700	OPERATION OF PLANT	10,094	10,094	1,273,045	0	6,070,563	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	239,382	8.00
9.00	00900	HOUSEKEEPING	180	180	962,583	0	1,998,754	9.00
10.00	01000	DIETARY	5,939	5,939	528,896	0	1,290,476	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	1,748	481,975	0	785,923	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	326,585	0	792,860	14.00
15.00	01500	PHARMACY	1,155	1,155	490,029	0	1,221,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	846,914	0	1,621,253	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	18,672	4,040,502	0	7,726,164	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	65,712	0	175,942	31.00
43.00	04300	NURSERY	420	420	12,622	0	42,576	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	10,982	976,630	0	2,989,307	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	887,513	0	1,631,580	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	1,755	92,910	0	234,757	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	8,409	2,374,489	0	5,073,243	54.00
60.00	06000	LABORATORY	2,774	2,774	1,086,490	0	4,481,076	60.00
65.00	06500	RESPIRATORY THERAPY	730	730	898,529	0	1,710,973	65.00
65.01	06501	SLEEP LAB	0	2,600	38,599	0	147,937	65.01
66.00	06600	PHYSICAL THERAPY	6,312	6,312	1,468,200	0	2,442,248	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	109,579	0	198,005	69.00
69.01	06901	CARDIAC REHABILITATION	630	630	81,631	0	160,175	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,047,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,908,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,194,584	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	11,100	0	0	2,414,746	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	83,246	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,789	364,441	0	1,633,265	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,529	517,062	0	2,428,520	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,496	141,264	0	1,802,654	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	212,592	0	979,403	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	119,355	0	298,659	88.04
90.00	09000	CLINIC	400	831	108,067	0	199,421	90.00
90.01	09001	CLINIC- ORTHO	0	3,976	464,764	0	775,508	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	5,980	408,230	0	967,115	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	1,200	92,384	0	2,707,396	90.03
90.04	09004	PSYCHIATRY	0	1,767	115,783	0	334,225	90.04
90.05	09005	CARDIOLOGY	0	1,472	390,414	0	852,555	90.05
91.00	09100	EMERGENCY	9,544	9,544	2,315,266	0	4,277,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,085	154,179	29,665,334	-16,165,563	66,940,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	580	0	0	30,885	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	101	0	0	1,850	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	36,581	0	79,358	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	1,017	195,862	0	1,052,941	194.05
194.06	07956	GUEST MEALS	0	0	27,837	0	67,600	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	137,301	0	202,591	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	247,140	0	608,281	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	232	134,467	0	434,854	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	56,090	0	268,484	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	536,778	0	1,258,651	194.17
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)	3,591,172	2,874,689	12,786,148		16,165,563	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.934599	18.315254	0.411960		0.227858	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			49,122		567,872	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001583		0.008004	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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	83,316					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	6,693				8.00
9.00	00900	HOUSEKEEPING	180	0	6,253			9.00
10.00	01000	DIETARY	5,939	0	104	6,173		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	36	0	0	14.00
15.00	01500	PHARMACY	1,155	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	6,073	1,521	6,073	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	100	3	100	0	31.00
43.00	04300	NURSERY	420	416	424	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	0	710	0	0	50.00
51.00	05100	RECOVERY ROOM	7,107	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	104	6	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	0	410	0	0	54.00
60.00	06000	LABORATORY	2,774	0	194	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	730	0	49	0	0	65.00
65.01	06501	SLEEP LAB	0	0	55	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,312	0	237	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	630	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	96	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	212	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	164	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	325	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	73	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	175	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	45	0	0	88.04
90.00	09000	CLINIC	400	0	55	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	191	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	153	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	110	0	0	90.05
91.00	09100	EMERGENCY	9,544	0	745	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,604	6,693	6,093	6,173	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	0	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	0	0	0	194.13

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF S ERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	0	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	25	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	135	0	0	194.17
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)	7,453,789	388,938	2,470,290	2,156,934	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	89.464077	58.111161	395.056773	349.414223	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	588,108	65,964	28,378	369,811	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.058764	9.855670	4.538302	59.907824	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	286,566					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,481,814				14.00
15.00	01500	PHARMACY	0	22,352	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,835	0	215,065,040		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,367	254,601	0	13,543,038		30.00
31.00	03100	INTENSIVE CARE UNIT	1,872	0	0	291,000		31.00
43.00	04300	NURSERY	0	0	0	406,000		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,944	498,798	0	14,819,368		50.00
51.00	05100	RECOVERY ROOM	18,720	0	0	6,768,212		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,736	0	0	1,283,079		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,292	0	50,938,802		54.00
60.00	06000	LABORATORY	0	3,250	0	29,649,393		60.00
65.00	06500	RESPIRATORY THERAPY	24,999	35,336	0	2,890,614		65.00
65.01	06501	SLEEP LAB	0	0	0	1,251,746		65.01
66.00	06600	PHYSICAL THERAPY	39,506	14,248	0	6,837,814		66.00
69.00	06900	ELECTROCARDIOLOGY	1,248	4,333	0	3,261,874		69.00
69.01	06901	CARDIAC REHABILITATION	2,966	1,286	0	652,243		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,852	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,908,354	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,612	2,359,052		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0	23,483,042		76.01
76.02	03030	DIABETIC EDUCATION	0	121	0	60,000		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	38,637	0	2,230,808		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	215,047	0	4,399,449		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	16,404	0	2,303,627		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	27,130	0	1,866,681		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	5,516	0	316,421		88.04
90.00	09000	CLINIC	2,516	17,444	0	580,000		90.00
90.01	09001	CLINIC- ORTHO	0	19,607	0	390,248		90.01
90.02	09002	CLINIC - PEDS ENT FP	0	20,358	0	832,358		90.02
90.03	09003	INTRAVENOUS THERAPY	2,244	12,910	4,388	8,717,590		90.03
90.04	09004	PSYCHIATRY	0	697	0	259,628		90.04
90.05	09005	CARDIOLOGY	11,977	2,134	0	2,627,110		90.05
91.00	09100	EMERGENCY	59,471	207,218	0	30,243,053		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286,566	3,440,760	10,000	213,262,250		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	6	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	54	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	0	0	0		194.11

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/14/2024 10:45 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
194.12	07962	TRINE STUDENT HEALTH	0	7,703	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	4,411	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0		194.14
194.15	07965	FOUNDATION	0	1,420	0	0		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	7,151	0	492,546		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	20,309	0	1,310,244		194.17
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)	1,024,048	1,266,511	1,611,805	1,992,790		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.573515	0.363750	161.180500	0.009266		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,785	194,947	81,463	34,920		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.233053	0.055990	8.146300	0.000162		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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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	14,791,794		14,791,794	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	372,923		372,923	0	0	31.00
43.00	04300	NURSERY	285,292		285,292	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,337,747		5,337,747	0	0	50.00
51.00	05100	RECOVERY ROOM	2,768,780		2,768,780	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,764		471,764	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,654,521		7,654,521	0	0	54.00
60.00	06000	LABORATORY	6,102,852		6,102,852	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,314,470	0	2,314,470	0	0	65.00
65.01	06501	SLEEP LAB	214,973	0	214,973	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,866,776	0	3,866,776	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	313,111		313,111	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	270,145		270,145	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,287,414		1,287,414	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,037,353		3,037,353	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,825		4,886,825	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,266,311		3,266,311	0	0	76.01
76.02	03030	DIABETIC EDUCATION	102,814		102,814	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,104,931		2,104,931	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,229,259		3,229,259	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,269,554		2,269,554	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,298,869		1,298,869	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	389,427		389,427	0	0	88.04
90.00	09000	CLINIC	323,085		323,085	0	0	90.00
90.01	09001	CLINIC- ORTHO	1,038,418		1,038,418	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,263,042		1,263,042	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	4,232,407		4,232,407	0	0	90.03
90.04	09004	PSYCHIATRY	413,041		413,041	0	0	90.04
90.05	09005	CARDIOLOGY	1,158,191		1,158,191	0	0	90.05
91.00	09100	EMERGENCY	6,968,506		6,968,506	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,581,516		4,581,516		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	86,616,111	0	86,616,111	0	0	200.00
201.00		Less Observation Beds	4,581,516		4,581,516		0	201.00
202.00		Total (see instructions)	82,034,595	0	82,034,595	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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	10,564,123		10,564,123			30.00
31.00	03100	INTENSIVE CARE UNIT	291,000		291,000			31.00
43.00	04300	NURSERY	406,000		406,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,040,028	12,779,340	14,819,368	0.360187	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,061,398	5,706,814	6,768,212	0.409086	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,280,600	2,479	1,283,079	0.367681	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,731,272	49,207,530	50,938,802	0.150269	0.000000	54.00
60.00	06000	LABORATORY	2,827,769	26,821,624	29,649,393	0.205834	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,485,197	1,405,417	2,890,614	0.800685	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,251,746	1,251,746	0.171739	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,369,935	5,467,879	6,837,814	0.565499	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	130,887	3,130,987	3,261,874	0.095991	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	3,600	648,643	652,243	0.414178	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	765,980	11,943,595	12,709,575	0.101295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,825	2,805,432	3,043,257	0.998060	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,359,052	7,941,222	10,300,274	0.474436	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	23,483,042	23,483,042	0.139092	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	4,720	55,280	60,000	1.713567	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,574	2,221,234	2,230,808			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,399,449	4,399,449			88.01
88.02	08802	RURAL HEALTH CLINIC III	831,626	1,472,001	2,303,627			88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,209	1,861,472	1,866,681			88.03
88.04	08804	RURAL HEALTH CLINIC V	2,384	314,037	316,421			88.04
90.00	09000	CLINIC	0	580,000	580,000	0.557043	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	390,248	390,248	2.660918	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	832,358	832,358	1.517426	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	8,717,590	8,717,590	0.485502	0.000000	90.03
90.04	09004	PSYCHIATRY	0	259,628	259,628	1.590895	0.000000	90.04
90.05	09005	CARDIOLOGY	110,888	2,516,222	2,627,110	0.440861	0.000000	90.05
91.00	09100	EMERGENCY	660,894	29,582,159	30,243,053	0.230417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	75,597	2,903,318	2,978,915	1.537981	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,255,558	208,700,746	236,956,304			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,255,558	208,700,746	236,956,304			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
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
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
76.02	03030	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- ORTHO	0.000000		90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000		90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000		90.03
90.04	09004	PSYCHIATRY	0.000000		90.04
90.05	09005	CARDIOLOGY	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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	14,791,794		14,791,794	0	14,791,794	30.00
31.00	03100	INTENSIVE CARE UNIT	372,923		372,923	0	372,923	31.00
43.00	04300	NURSERY	285,292		285,292	0	285,292	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,337,747		5,337,747	0	5,337,747	50.00
51.00	05100	RECOVERY ROOM	2,768,780		2,768,780	0	2,768,780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,764		471,764	0	471,764	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,654,521		7,654,521	0	7,654,521	54.00
60.00	06000	LABORATORY	6,102,852		6,102,852	0	6,102,852	60.00
65.00	06500	RESPIRATORY THERAPY	2,314,470	0	2,314,470	0	2,314,470	65.00
65.01	06501	SLEEP LAB	214,973	0	214,973	0	214,973	65.01
66.00	06600	PHYSICAL THERAPY	3,866,776	0	3,866,776	0	3,866,776	66.00
69.00	06900	ELECTROCARDIOLOGY	313,111		313,111	0	313,111	69.00
69.01	06901	CARDIAC REHABILITATION	270,145		270,145	0	270,145	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,287,414		1,287,414	0	1,287,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,037,353		3,037,353	0	3,037,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,825		4,886,825	0	4,886,825	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,266,311		3,266,311	0	3,266,311	76.01
76.02	03030	DIABETIC EDUCATION	102,814		102,814	0	102,814	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,104,931		2,104,931	0	2,104,931	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,229,259		3,229,259	0	3,229,259	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,269,554		2,269,554	0	2,269,554	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,298,869		1,298,869	0	1,298,869	88.03
88.04	08804	RURAL HEALTH CLINIC V	389,427		389,427	0	389,427	88.04
90.00	09000	CLINIC	323,085		323,085	0	323,085	90.00
90.01	09001	CLINIC- ORTHO	1,038,418		1,038,418	0	1,038,418	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,263,042		1,263,042	0	1,263,042	90.02
90.03	09003	INTRAVENOUS THERAPY	4,232,407		4,232,407	0	4,232,407	90.03
90.04	09004	PSYCHIATRY	413,041		413,041	0	413,041	90.04
90.05	09005	CARDIOLOGY	1,158,191		1,158,191	0	1,158,191	90.05
91.00	09100	EMERGENCY	6,968,506		6,968,506	0	6,968,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,581,516		4,581,516		4,581,516	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	86,616,111	0	86,616,111	0	86,616,111	200.00
201.00		Less Observation Beds	4,581,516		4,581,516		4,581,516	201.00
202.00		Total (see instructions)	82,034,595	0	82,034,595	0	82,034,595	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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	10,564,123		10,564,123			30.00
31.00	03100	INTENSIVE CARE UNIT	291,000		291,000			31.00
43.00	04300	NURSERY	406,000		406,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,040,028	12,779,340	14,819,368	0.360187	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,061,398	5,706,814	6,768,212	0.409086	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,280,600	2,479	1,283,079	0.367681	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,731,272	49,207,530	50,938,802	0.150269	0.000000	54.00
60.00	06000	LABORATORY	2,827,769	26,821,624	29,649,393	0.205834	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,485,197	1,405,417	2,890,614	0.800685	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,251,746	1,251,746	0.171739	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,369,935	5,467,879	6,837,814	0.565499	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	130,887	3,130,987	3,261,874	0.095991	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	3,600	648,643	652,243	0.414178	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	765,980	11,943,595	12,709,575	0.101295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,825	2,805,432	3,043,257	0.998060	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,359,052	7,941,222	10,300,274	0.474436	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	23,483,042	23,483,042	0.139092	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	4,720	55,280	60,000	1.713567	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,574	2,221,234	2,230,808	0.943573	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,399,449	4,399,449	0.734014	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	831,626	1,472,001	2,303,627	0.985209	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,209	1,861,472	1,866,681	0.695817	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,384	314,037	316,421	1.230724	0.000000	88.04
90.00	09000	CLINIC	0	580,000	580,000	0.557043	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	390,248	390,248	2.660918	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	832,358	832,358	1.517426	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	8,717,590	8,717,590	0.485502	0.000000	90.03
90.04	09004	PSYCHIATRY	0	259,628	259,628	1.590895	0.000000	90.04
90.05	09005	CARDIOLOGY	110,888	2,516,222	2,627,110	0.440861	0.000000	90.05
91.00	09100	EMERGENCY	660,894	29,582,159	30,243,053	0.230417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	75,597	2,903,318	2,978,915	1.537981	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	28,255,558	208,700,746	236,956,304			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,255,558	208,700,746	236,956,304			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/14/2024 10:45 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.360187	50.00
51.00	05100	RECOVERY ROOM	0.409086	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367681	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150269	54.00
60.00	06000	LABORATORY	0.205834	60.00
65.00	06500	RESPIRATORY THERAPY	0.800685	65.00
65.01	06501	SLEEP LAB	0.171739	65.01
66.00	06600	PHYSICAL THERAPY	0.565499	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095991	69.00
69.01	06901	CARDIAC REHABILITATION	0.414178	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.101295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.998060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474436	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	76.00
76.01	03480	ONCOLOGY	0.139092	76.01
76.02	03030	DIABETIC EDUCATION	1.713567	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.943573	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.734014	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.985209	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.695817	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.230724	88.04
90.00	09000	CLINIC	0.557043	90.00
90.01	09001	CLINIC- ORTHO	2.660918	90.01
90.02	09002	CLINIC - PEDS ENT FP	1.517426	90.02
90.03	09003	INTRAVENOUS THERAPY	0.485502	90.03
90.04	09004	PSYCHIATRY	1.590895	90.04
90.05	09005	CARDIOLOGY	0.440861	90.05
91.00	09100	EMERGENCY	0.230417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.537981	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/14/2024 10:45 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	5,337,747	726,912	4,610,835	0	0	50.00
51.00	05100	RECOVERY ROOM	2,768,780	448,537	2,320,243	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,764	109,532	362,232	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,654,521	567,701	7,086,820	0	0	54.00
60.00	06000	LABORATORY	6,102,852	210,749	5,892,103	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,314,470	67,636	2,246,834	0	0	65.00
65.01	06501	SLEEP LAB	214,973	49,318	165,655	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,866,776	414,729	3,452,047	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	313,111	25,556	287,555	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	270,145	40,275	229,870	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,287,414	8,492	1,278,922	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,037,353	122,124	2,915,229	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,825	72,104	4,814,721	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	3,266,311	227,393	3,038,918	0	0	76.01
76.02	03030	DIABETIC EDUCATION	102,814	683	102,131	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,104,931	141,260	1,963,671	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,229,259	154,065	3,075,194	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,269,554	80,304	2,189,250	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,298,869	10,791	1,288,078	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	389,427	3,143	386,284	0	0	88.04
90.00	09000	CLINIC	323,085	35,692	287,393	0	0	90.00
90.01	09001	CLINIC- ORTHO	1,038,418	81,792	956,626	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,263,042	119,881	1,143,161	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	4,232,407	132,591	4,099,816	0	0	90.03
90.04	09004	PSYCHIATRY	413,041	35,302	377,739	0	0	90.04
90.05	09005	CARDIOLOGY	1,158,191	38,237	1,119,954	0	0	90.05
91.00	09100	EMERGENCY	6,968,506	647,230	6,321,276	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,581,516	515,269	4,066,247	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	71,166,102	5,087,298	66,078,804	0	0	200.00
201.00		Less Observation Beds	4,581,516	515,269	4,066,247	0	0	201.00
202.00		Total (line 200 minus line 201)	66,584,586	4,572,029	62,012,557	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/14/2024 10:45 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	5,337,747	14,819,368	0.360187		50.00
51.00	05100	RECOVERY ROOM	2,768,780	6,768,212	0.409086		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,764	1,283,079	0.367681		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,654,521	50,938,802	0.150269		54.00
60.00	06000	LABORATORY	6,102,852	29,649,393	0.205834		60.00
65.00	06500	RESPIRATORY THERAPY	2,314,470	2,890,614	0.800685		65.00
65.01	06501	SLEEP LAB	214,973	1,251,746	0.171739		65.01
66.00	06600	PHYSICAL THERAPY	3,866,776	6,837,814	0.565499		66.00
69.00	06900	ELECTROCARDIOLOGY	313,111	3,261,874	0.095991		69.00
69.01	06901	CARDIAC REHABILITATION	270,145	652,243	0.414178		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,287,414	12,709,575	0.101295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,037,353	3,043,257	0.998060		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,886,825	10,300,274	0.474436		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000		76.00
76.01	03480	ONCOLOGY	3,266,311	23,483,042	0.139092		76.01
76.02	03030	DIABETIC EDUCATION	102,814	60,000	1.713567		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,104,931	2,230,808	0.943573		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,229,259	4,399,449	0.734014		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,269,554	2,303,627	0.985209		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,298,869	1,866,681	0.695817		88.03
88.04	08804	RURAL HEALTH CLINIC V	389,427	316,421	1.230724		88.04
90.00	09000	CLINIC	323,085	580,000	0.557043		90.00
90.01	09001	CLINIC- ORTHO	1,038,418	390,248	2.660918		90.01
90.02	09002	CLINIC - PEDS ENT FP	1,263,042	832,358	1.517426		90.02
90.03	09003	INTRAVENOUS THERAPY	4,232,407	8,717,590	0.485502		90.03
90.04	09004	PSYCHIATRY	413,041	259,628	1.590895		90.04
90.05	09005	CARDIOLOGY	1,158,191	2,627,110	0.440861		90.05
91.00	09100	EMERGENCY	6,968,506	30,243,053	0.230417		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,581,516	2,978,915	1.537981		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	71,166,102	225,695,181			200.00
201.00		Less Observation Beds	4,581,516	0			201.00
202.00		Total (line 200 minus line 201)	66,584,586	225,695,181			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/14/2024 10:45 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	726,912	14,819,368	0.049051	436,243	21,398	50.00
51.00	05100	RECOVERY ROOM	448,537	6,768,212	0.066271	174,060	11,535	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,532	1,283,079	0.085367	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,701	50,938,802	0.011145	376,596	4,197	54.00
60.00	06000	LABORATORY	210,749	29,649,393	0.007108	657,568	4,674	60.00
65.00	06500	RESPIRATORY THERAPY	67,636	2,890,614	0.023398	308,627	7,221	65.00
65.01	06501	SLEEP LAB	49,318	1,251,746	0.039399	0	0	65.01
66.00	06600	PHYSICAL THERAPY	414,729	6,837,814	0.060652	198,858	12,061	66.00
69.00	06900	ELECTROCARDIOLOGY	25,556	3,261,874	0.007835	31,378	246	69.00
69.01	06901	CARDIAC REHABILITATION	40,275	652,243	0.061748	1,684	104	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,492	12,709,575	0.000668	257,631	172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,124	3,043,257	0.040129	77,055	3,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,104	10,300,274	0.007000	522,559	3,658	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	227,393	23,483,042	0.009683	0	0	76.01
76.02	03030	DIABETIC EDUCATION	683	60,000	0.011383	4,720	54	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,260	2,230,808	0.063322	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	154,065	4,399,449	0.035019	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	80,304	2,303,627	0.034860	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,791	1,866,681	0.005781	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,143	316,421	0.009933	0	0	88.04
90.00	09000	CLINIC	35,692	580,000	0.061538	0	0	90.00
90.01	09001	CLINIC- ORTHO	81,792	390,248	0.209590	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	119,881	832,358	0.144026	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	132,591	8,717,590	0.015210	0	0	90.03
90.04	09004	PSYCHIATRY	35,302	259,628	0.135971	0	0	90.04
90.05	09005	CARDIOLOGY	38,237	2,627,110	0.014555	110,888	1,614	90.05
91.00	09100	EMERGENCY	647,230	30,243,053	0.021401	40,441	865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	515,269	2,978,915	0.172972	0	0	92.00
200.00		Total (lines 50 through 199)	5,087,298	225,695,181		3,198,308	70,891	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/14/2024 10:45 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/14/2024 10:45 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	14,819,368	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,768,212	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,283,079	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,938,802	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	29,649,393	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,890,614	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,251,746	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,837,814	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,261,874	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	652,243	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,709,575	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,043,257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,300,274	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	23,483,042	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	60,000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,230,808	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,399,449	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,303,627	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,866,681	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	316,421	0.000000	88.04
90.00	09000	CLINIC	0	0	0	580,000	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	390,248	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	832,358	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	8,717,590	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	259,628	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	2,627,110	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	30,243,053	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,978,915	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	225,695,181		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/14/2024 10:45 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	436,243	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	174,060	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	376,596	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	657,568	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	308,627	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	198,858	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	31,378	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	1,684	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	257,631	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	77,055	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	522,559	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	4,720	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	110,888	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	40,441	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,198,308	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/14/2024 10:45 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	0.360187	0	2,689,043	0	0	50.00
51.00	05100	RECOVERY ROOM	0.409086	0	817,548	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367681	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150269	0	10,866,446	0	0	54.00
60.00	06000	LABORATORY	0.205834	0	4,722,874	93	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.800685	0	207,088	0	0	65.00
65.01	06501	SLEEP LAB	0.171739	0	145,142	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.565499	0	1,030,080	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095991	0	596,983	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.414178	0	189,516	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.101295	0	407,641	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.998060	0	601,295	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474436	0	2,195,104	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.139092	0	8,197,796	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.713567	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
90.00	09000	CLINIC	0.557043	0	94,344	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.660918	0	199,708	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1.517426	0	70,966	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.485502	0	3,493,221	26,738	0	90.03
90.04	09004	PSYCHIATRY	1.590895	0	27,304	0	0	90.04
90.05	09005	CARDIOLOGY	0.440861	0	504,810	0	0	90.05
91.00	09100	EMERGENCY	0.230417	0	4,374,489	3,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.537981	0	926,620	0	0	92.00
200.00		Subtotal (see instructions)		0	42,358,018	30,584	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	42,358,018	30,584	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/14/2024 10:45 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	968,558	0		50.00
51.00	05100	RECOVERY ROOM	334,447	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,632,890	0		54.00
60.00	06000	LABORATORY	972,128	19		60.00
65.00	06500	RESPIRATORY THERAPY	165,812	0		65.00
65.01	06501	SLEEP LAB	24,927	0		65.01
66.00	06600	PHYSICAL THERAPY	582,509	0		66.00
69.00	06900	ELECTROCARDIOLOGY	57,305	0		69.00
69.01	06901	CARDIAC REHABILITATION	78,493	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,292	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	600,128	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,041,436	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	1,140,248	0		76.01
76.02	03030	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	52,554	0		90.00
90.01	09001	CLINIC- ORTHO	531,407	0		90.01
90.02	09002	CLINIC - PEDS ENT FP	107,686	0		90.02
90.03	09003	INTRAVENOUS THERAPY	1,695,966	12,981		90.03
90.04	09004	PSYCHIATRY	43,438	0		90.04
90.05	09005	CARDIOLOGY	222,551	0		90.05
91.00	09100	EMERGENCY	1,007,957	865		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,425,124	0		92.00
200.00		Subtotal (see instructions)	12,726,856	13,865		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,726,856	13,865		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I | Date/Time Prepared: 2/14/2024 10:45 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	1,663,591	296,751	1,366,840	4,926	277.47	30.00
31.00	INTENSIVE CARE UNIT	80,150		80,150	100	801.50	31.00
43.00	NURSERY	31,781		31,781	416	76.40	43.00
200.00	Total (lines 30 through 199)	1,775,522		1,478,771	5,442		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	78	21,643				30.00
31.00	INTENSIVE CARE UNIT	3	2,405				31.00
43.00	NURSERY	35	2,674				43.00
200.00	Total (lines 30 through 199)	116	26,722				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/14/2024 10:45 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	726,912	14,819,368	0.049051	19,721	967	50.00
51.00	05100	RECOVERY ROOM	448,537	6,768,212	0.066271	10,648	706	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,532	1,283,079	0.085367	13,950	1,191	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,701	50,938,802	0.011145	52,158	581	54.00
60.00	06000	LABORATORY	210,749	29,649,393	0.007108	71,179	506	60.00
65.00	06500	RESPIRATORY THERAPY	67,636	2,890,614	0.023398	26,818	627	65.00
65.01	06501	SLEEP LAB	49,318	1,251,746	0.039399	0	0	65.01
66.00	06600	PHYSICAL THERAPY	414,729	6,837,814	0.060652	3,698	224	66.00
69.00	06900	ELECTROCARDIOLOGY	25,556	3,261,874	0.007835	3,960	31	69.00
69.01	06901	CARDIAC REHABILITATION	40,275	652,243	0.061748	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,492	12,709,575	0.000668	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,124	3,043,257	0.040129	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,104	10,300,274	0.007000	65,081	456	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	227,393	23,483,042	0.009683	0	0	76.01
76.02	03030	DIABETIC EDUCATION	683	60,000	0.011383	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,260	2,230,808	0.063322	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	154,065	4,399,449	0.035019	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	80,304	2,303,627	0.034860	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,791	1,866,681	0.005781	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,143	316,421	0.009933	0	0	88.04
90.00	09000	CLINIC	35,692	580,000	0.061538	0	0	90.00
90.01	09001	CLINIC- ORTHO	81,792	390,248	0.209590	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	119,881	832,358	0.144026	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	132,591	8,717,590	0.015210	0	0	90.03
90.04	09004	PSYCHIATRY	35,302	259,628	0.135971	0	0	90.04
90.05	09005	CARDIOLOGY	38,237	2,627,110	0.014555	0	0	90.05
91.00	09100	EMERGENCY	647,230	30,243,053	0.021401	42,841	917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	515,269	2,978,915	0.172972	0	0	92.00
200.00		Total (lines 50 through 199)	5,087,298	225,695,181		310,054	6,206	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/14/2024 10:45 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
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	4,926	0.00	78	30.00
31.00	03100	INTENSIVE CARE UNIT		0	100	0.00	3	31.00
43.00	04300	NURSERY		0	416	0.00	35	43.00
200.00		Total (lines 30 through 199)		0	5,442		116	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/14/2024 10:45 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/14/2024 10:45 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	14,819,368	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,768,212	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,283,079	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,938,802	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	29,649,393	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,890,614	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,251,746	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,837,814	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,261,874	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	652,243	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,709,575	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,043,257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,300,274	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	23,483,042	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	60,000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,230,808	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,399,449	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,303,627	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,866,681	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	316,421	0.000000	88.04
90.00	09000	CLINIC	0	0	0	580,000	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	390,248	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	832,358	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	8,717,590	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	259,628	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	2,627,110	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	30,243,053	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,978,915	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	225,695,181		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/14/2024 10:45 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	19,721	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	10,648	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,950	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,158	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	71,179	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,818	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,698	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,960	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	65,081	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	42,841	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		310,054	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,073	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,926	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)	3,069	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	259	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)	803	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	64	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	888	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)	91	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)	284	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	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,791,794	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)	4,556	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)	13,885	25.00
26.00	Total swing-bed cost (see instructions)	2,638,565	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,153,229	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,153,229	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)	2,467.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,190,838	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)	2,190,838	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 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	372,923	100	3,729.23	30	111,877	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)	1,200,768	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)	3,503,483	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)	224,512	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	700,673	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	925,185	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)	1,857	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,467.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,581,516	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,663,591	14,791,794	0.112467	4,581,516	515,269	90.00
91.00	Nursing Program cost	0	14,791,794	0.000000	4,581,516	0	91.00
92.00	Allied health cost	0	14,791,794	0.000000	4,581,516	0	92.00
93.00	All other Medical Education	0	14,791,794	0.000000	4,581,516	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 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)	6,073	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,926	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)	3,069	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	259	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)	803	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	64	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	78	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)	416	15.00
16.00	Nursery days (title V or XIX only)	35	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	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,791,794	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)	4,556	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)	13,885	25.00
26.00	Total swing-bed cost (see instructions)	2,638,565	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,153,229	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,153,229	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)	2,467.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	192,438	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)	192,438	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 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)	285,292	416	685.80	35	24,003	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	372,923	100	3,729.23	3	11,188	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)	103,769	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)	331,398	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)	26,722	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,206	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	32,928	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	298,470	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)	1,857	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,467.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,581,516	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/14/2024 10:45 am

Title XIX | Hospital | PPS

	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	1,663,591	14,791,794	0.112467	4,581,516	515,269	90.00
91.00	Nursing Program cost	0	14,791,794	0.000000	4,581,516	0	91.00
92.00	Allied health cost	0	14,791,794	0.000000	4,581,516	0	92.00
93.00	All other Medical Education	0	14,791,794	0.000000	4,581,516	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/14/2024 10:45 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		1,628,817		30.00
31.00	03100	INTENSIVE CARE UNIT		90,000		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.360187	436,243	157,129	50.00
51.00	05100	RECOVERY ROOM	0.409086	174,060	71,206	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367681	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150269	376,596	56,591	54.00
60.00	06000	LABORATORY	0.205834	657,568	135,350	60.00
65.00	06500	RESPIRATORY THERAPY	0.800685	308,627	247,113	65.00
65.01	06501	SLEEP LAB	0.171739	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.565499	198,858	112,454	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095991	31,378	3,012	69.00
69.01	06901	CARDIAC REHABILITATION	0.414178	1,684	697	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.101295	257,631	26,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.998060	77,055	76,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474436	522,559	247,921	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.139092	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.713567	4,720	8,088	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000	CLINIC	0.557043	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.660918	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1.517426	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.485502	0	0	90.03
90.04	09004	PSYCHIATRY	1.590895	0	0	90.04
90.05	09005	CARDIOLOGY	0.440861	110,888	48,886	90.05
91.00	09100	EMERGENCY	0.230417	40,441	9,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.537981	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,198,308	1,200,768	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)		3,198,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/14/2024 10:45 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.360187	0	0	50.00
51.00	05100	RECOVERY ROOM	0.409086	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367681	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150269	26,118	3,925	54.00
60.00	06000	LABORATORY	0.205834	63,047	12,977	60.00
65.00	06500	RESPIRATORY THERAPY	0.800685	8,419	6,741	65.00
65.01	06501	SLEEP LAB	0.171739	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.565499	301,053	170,245	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095991	8,606	826	69.00
69.01	06901	CARDIAC REHABILITATION	0.414178	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.101295	14,600	1,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.998060	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474436	159,553	75,698	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.139092	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.713567	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000	CLINIC	0.557043	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.660918	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1.517426	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.485502	0	0	90.03
90.04	09004	PSYCHIATRY	1.590895	0	0	90.04
90.05	09005	CARDIOLOGY	0.440861	0	0	90.05
91.00	09100	EMERGENCY	0.230417	270	62	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.537981	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		581,666	271,953	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)		581,666		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/14/2024 10:45 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		148,333		30.00
31.00	03100	INTENSIVE CARE UNIT		9,000		31.00
43.00	04300	NURSERY		10,000		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.360187	19,721	7,103	50.00
51.00	05100	RECOVERY ROOM	0.409086	10,648	4,356	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.367681	13,950	5,129	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150269	52,158	7,838	54.00
60.00	06000	LABORATORY	0.205834	71,179	14,651	60.00
65.00	06500	RESPIRATORY THERAPY	0.800685	26,818	21,473	65.00
65.01	06501	SLEEP LAB	0.171739	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.565499	3,698	2,091	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095991	3,960	380	69.00
69.01	06901	CARDIAC REHABILITATION	0.414178	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.101295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.998060	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474436	65,081	30,877	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.139092	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.713567	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.943573	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.734014	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.985209	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.695817	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.230724	0	0	88.04
90.00	09000	CLINIC	0.557043	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.660918	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1.517426	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.485502	0	0	90.03
90.04	09004	PSYCHIATRY	1.590895	0	0	90.04
90.05	09005	CARDIOLOGY	0.440861	0	0	90.05
91.00	09100	EMERGENCY	0.230417	42,841	9,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.537981	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		310,054	103,769	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)		310,054		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/14/2024 10:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,740,721	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,740,721	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)	12,868,128	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)	99,856	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7,396,075	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)	5,372,197	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	5,372,197	30.00
31.00	Primary payer payments	1,651	31.00
32.00	Subtotal (line 30 minus line 31)	5,370,546	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)	505,302	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	328,446	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	505,302	36.00
37.00	Subtotal (see instructions)	5,698,992	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)	5,698,992	40.00
40.01	Sequestration adjustment (see instructions)	113,980	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	6,344,471	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)	-759,459	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/14/2024 10:45 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/14/2024 10:45 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		2,633,791		6,344,471	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)		2,633,791		6,344,471	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		492,040		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		759,459	6.02
7.00	Total Medicare program liability (see instructions)		3,125,831		5,585,012	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/14/2024 10:45 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		912,144		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		912,144		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		268,864		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,181,008		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/14/2024 10:45 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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/14/2024 10:45 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)	934,437	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)	274,673	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	375	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)	1,209,110	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,209,110	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)	1,209,110	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,000	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,205,110	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)	1,205,110	0	19.00
19.01	Sequestration adjustment (see instructions)	24,102	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	912,144	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)	268,864	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/14/2024 10:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,503,483	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)	3,503,483	4.00
5.00	Primary payer payments	4,194	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,534,324	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)	3,534,324	19.00
20.00	Deductibles (exclude professional component)	352,334	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,181,990	22.00
23.00	Coinsurance	800	23.00
24.00	Subtotal (line 22 minus line 23)	3,181,190	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,974	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,433	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,974	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,189,623	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)	3,189,623	30.00
30.01	Sequestration adjustment (see instructions)	63,792	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,633,791	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)	492,040	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 2/14/2024 10:45 am

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	36,553		8.00
9.00	Ancillary service charges	310,054	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	346,607	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	346,607	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	346,607	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	126,306	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	126,306	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	126,306	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	126,306	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	261	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	126,045	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	126,045	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	126,045	0	40.00
41.00	Interim payments	126,045	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/14/2024 10:45 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	19,799,139	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	11,347,875	0	0	0	4.00
5.00	Other receivable	1,471,166	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,476,431	0	0	0	7.00
8.00	Prepaid expenses	1,474,958	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	35,569,569	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,019,703	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	61,381,451	0	0	0	15.00
16.00	Accumulated depreciation	-35,061,466	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	21,206,348	0	0	0	23.00
24.00	Accumulated depreciation	-17,026,027	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	838,453	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,358,462	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	36,624,445	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,085,715	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	46,710,160	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	115,638,191	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,846,830	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,258,402	0	0	0	38.00
39.00	Payroll taxes payable	66,342	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,196,835	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	455,527	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,823,936	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	43,626,027	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,626,027	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,449,963	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	60,188,228				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)	60,188,228	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	115,638,191	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/14/2024 10:45 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		53,849,695		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,338,538				2.00
3.00	Total (sum of line 1 and line 2)		60,188,233		0		3.00
4.00	ROUNDING	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)		60,188,233		0		11.00
12.00	ROUNDING	5		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)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60,188,228		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	ROUNDING		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	ROUNDING		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: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/14/2024 10:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,970,123		10,970,123	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	10,970,123		10,970,123	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	291,000		291,000	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)	291,000		291,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,261,123		11,261,123	17.00
18.00	Ancillary services	16,034,754	185,136,507	201,171,261	18.00
19.00	Outpatient services	110,888	12,354,453	12,465,341	19.00
20.00	RURAL HEALTH CLINIC	9,574	2,221,234	2,230,808	20.00
20.01	RURAL HEALTH CLINIC II	0	4,275,352	4,275,352	20.01
20.02	RURAL HEALTH CLINIC III	831,626	1,472,001	2,303,627	20.02
20.03	RURAL HEALTH CLINIC IV	5,209	1,861,472	1,866,681	20.03
20.04	RURAL HEALTH CLINIC V	2,384	314,037	316,421	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				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	NON REIMBURSABLE	0	1,802,790	1,802,790	27.00
27.01	PROFESSIONAL FEES	549,603	5,449,347	5,998,950	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,805,161	214,887,193	243,692,354	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,827,185		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)		98,827,185		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/14/2024 10:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	243,692,354	1.00
2.00	Less contractual allowances and discounts on patients' accounts	146,263,080	2.00
3.00	Net patient revenues (line 1 minus line 2)	97,429,274	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,827,185	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,397,911	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	361,086	6.00
7.00	Income from investments	984,773	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	310,158	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	838,018	24.00
24.01	340B CONTRACT REVENUE	572,649	24.01
24.02	PHYISICAN INCENTIVE PAYMENTS	188,485	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	3,630,134	24.03
24.50	COVID-19 PHE Funding	859,143	24.50
25.00	Total other income (sum of lines 6-24)	7,744,446	25.00
26.00	Total (line 5 plus line 25)	6,346,535	26.00
27.00	LOSS ON DISPOSAL OF PROPERTY	7,997	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	7,997	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,338,538	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	432,532	30,229	462,761	75,488	538,249	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	250,858	0	250,858	61,928	312,786	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	218,687	0	218,687	0	218,687	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	21,420	0	21,420	0	21,420	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	75,416	0	75,416	0	75,416	9.00
10.00	Subtotal (sum of lines 1 through 9)	998,913	30,229	1,029,142	137,416	1,166,558	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	42,152	42,152	0	42,152	15.00
16.00	Transportation (Health Care Staff)	0	3,825	3,825	0	3,825	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	45,977	45,977	0	45,977	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	998,913	76,206	1,075,119	137,416	1,212,535	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	10,396	10,396	0	10,396	29.00
30.00	Administrative Costs	77,411	58,446	135,857	0	135,857	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	77,411	68,842	146,253	0	146,253	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,076,324	145,048	1,221,372	137,416	1,358,788	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	538,249		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	312,786		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	218,687		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	21,420		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	75,416		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,166,558		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	42,152		15.00
16.00	Transportation (Health Care Staff)	0	3,825		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	45,977		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,212,535		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	10,396		29.00
30.00	Administrative Costs	0	135,857		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	146,253		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,358,788		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	565,082	0	565,082	139,640	704,722	1.00
2.00	Physician Assistant	140,744	0	140,744	24,688	165,432	2.00
3.00	Nurse Practitioner	333,714	0	333,714	80,954	414,668	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	183,496	0	183,496	0	183,496	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	194,700	0	194,700	0	194,700	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,417,736	0	1,417,736	245,282	1,663,018	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	223,808	223,808	0	223,808	15.00
16.00	Transportation (Health Care Staff)	0	106	106	0	106	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	223,914	223,914	0	223,914	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,417,736	223,914	1,641,650	245,282	1,886,932	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	21,990	21,990	0	21,990	29.00
30.00	Administrative Costs	128,193	58,816	187,009	0	187,009	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	128,193	80,806	208,999	0	208,999	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,545,929	304,720	1,850,649	245,282	2,095,931	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	704,722		1.00
2.00	Physician Assistant	0	165,432		2.00
3.00	Nurse Practitioner	0	414,668		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	183,496		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	194,700		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,663,018		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	223,808		15.00
16.00	Transportation (Health Care Staff)	0	106		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	223,914		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,886,932		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	21,990		29.00
30.00	Administrative Costs	0	187,009		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	208,999		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,095,931		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	600,535	281,635	882,170	123,026	1,005,196	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	267,314	0	267,314	53,793	321,107	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	94,668	0	94,668	0	94,668	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	139,206	0	139,206	0	139,206	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,101,723	281,635	1,383,358	176,819	1,560,177	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	21,105	21,105	0	21,105	15.00
16.00	Transportation (Health Care Staff)	0	6,030	6,030	0	6,030	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	27,135	27,135	0	27,135	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,101,723	308,770	1,410,493	176,819	1,587,312	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	65,394	65,394	0	65,394	29.00
30.00	Administrative Costs	67,554	32,913	100,467	0	100,467	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,554	98,307	165,861	0	165,861	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,169,277	407,077	1,576,354	176,819	1,753,173	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	-47,713	957,483		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-25,031	296,076		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	94,668		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	139,206		9.00
10.00	Subtotal (sum of lines 1 through 9)	-72,744	1,487,433		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	21,105		15.00
16.00	Transportation (Health Care Staff)	0	6,030		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	27,135		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-72,744	1,514,568		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	65,394		29.00
30.00	Administrative Costs	0	100,467		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	165,861		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-72,744	1,680,429		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	405,321	0	405,321	-17,745	387,576	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	226,275	0	226,275	-13,969	212,306	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	116,035	0	116,035	-24,210	91,825	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	117,579	0	117,579	-24,532	93,047	9.00
10.00	Subtotal (sum of lines 1 through 9)	865,210	0	865,210	-80,456	784,754	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	34,679	34,679	-7,236	27,443	15.00
16.00	Transportation (Health Care Staff)	0	4,263	4,263	-889	3,374	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	38,942	38,942	-8,125	30,817	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	865,210	38,942	904,152	-88,581	815,571	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	9,447	9,447	2,172	11,619	29.00
30.00	Administrative Costs	65,587	65,181	130,768	-27,289	103,479	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	65,587	74,628	140,215	-25,117	115,098	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	930,797	113,570	1,044,367	-113,698	930,669	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	-38,845	348,731		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	212,306		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	91,825		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	93,047		9.00
10.00	Subtotal (sum of lines 1 through 9)	-38,845	745,909		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	27,443		15.00
16.00	Transportation (Health Care Staff)	0	3,374		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	30,817		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-38,845	776,726		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	11,619		29.00
30.00	Administrative Costs	0	103,479		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	115,098		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-38,845	891,824		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	556,047	0	556,047	-424,624	131,423	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	109,984	0	109,984	-81,761	28,223	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	221,479	0	221,479	-174,170	47,309	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	19,475	0	19,475	-15,315	4,160	9.00
10.00	Subtotal (sum of lines 1 through 9)	906,985	0	906,985	-695,870	211,115	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	27,171	27,171	-21,367	5,804	15.00
16.00	Transportation (Health Care Staff)	0	4,739	4,739	-3,726	1,013	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	31,910	31,910	-25,093	6,817	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	906,985	31,910	938,895	-720,963	217,932	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	11,582	11,582	-7,799	3,783	29.00
30.00	Administrative Costs	78,183	51,848	130,031	-102,256	27,775	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	78,183	63,430	141,613	-110,055	31,558	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	985,168	95,340	1,080,508	-831,018	249,490	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/14/2024 10:45 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	131,423		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	28,223		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	47,309		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	4,160		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	211,115		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	5,804		15.00
16.00	Transportation (Health Care Staff)	0	1,013		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,817		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	217,932		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	3,783		29.00
30.00	Administrative Costs	0	27,775		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	31,558		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	249,490		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/14/2024 10:45 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	0.64	3,307	4,200	2,688		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.51	5,196	2,100	3,171		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.15	8,503		5,859	8,503	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.08	243			243	6.00
7.00	Clinical Social Worker	0.19	209			209	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.42	8,955			8,955	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)					1,212,535	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)					1,212,535	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)					146,253	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					746,143	15.00
16.00	Total overhead (sum of lines 14 and 15)					892,396	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					892,396	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					892,396	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,104,931	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/14/2024 10:45 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	1.42	5,138	4,200	5,964		1.00
2.00	Physician Assistant	0.77	4,065	2,100	1,617		2.00
3.00	Nurse Practitioner	1.90	10,310	2,100	3,990		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.09	19,513		11,571	19,513	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.09	19,513			19,513	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)					1,886,932	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)					1,886,932	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)					208,999	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,133,328	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,342,327	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,342,327	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,342,327	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,229,259	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/14/2024 10:45 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	0.43	2,161	4,200	1,806		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.03	4,238	2,100	2,163		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.46	6,399		3,969	6,399	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.46	6,399			6,399	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)					1,514,568	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)					1,514,568	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)					165,861	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					589,125	15.00
16.00	Total overhead (sum of lines 14 and 15)					754,986	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					754,986	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					754,986	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,269,554	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/14/2024 10:45 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	0.64	3,255	4,200	2,688		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.11	3,569	2,100	2,331		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.75	6,824		5,019	6,824	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.75	6,824			6,824	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)					776,726	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)					776,726	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)					115,098	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					407,045	15.00
16.00	Total overhead (sum of lines 14 and 15)					522,143	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					522,143	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					522,143	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,298,869	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/14/2024 10:45 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	0.33	896	4,200	1,386		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.15	405	2,100	315		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.48	1,301		1,701	1,701	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.48	1,301			1,701	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)					217,932	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)					217,932	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)					31,558	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					139,937	15.00
16.00	Total overhead (sum of lines 14 and 15)					171,495	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					171,495	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					171,495	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					389,427	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/14/2024 10:45 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)			2,104,931	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			48,031	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,056,900	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,955	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)			8,955	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			229.69	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	275.29	285.75		8.00
9.00	Rate for Program covered visits (see instructions)	229.69	229.69		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	279	828		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	64,084	190,183		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	254,267		16.00
16.01	Total program charges (see instructions)(from contractor's records)		237,433		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,844		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,826		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.)		171,304		16.04
16.05	Total program cost (see instructions)	0	186,130		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,311		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,636		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		186,130		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,108		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		224,238		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)		224,238		26.00
26.01	Sequestration adjustment (see instructions)		4,485		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		211,105		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)		8,648		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: 15-1315 Component CCN: 15-8545	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/14/2024 10:45 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)		3,229,259	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,229,259	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		19,513	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)		19,513	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		165.49	7.00
		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	228.60	237.29	8.00
9.00	Rate for Program covered visits (see instructions)	165.49	165.49	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	281	832	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	46,503	137,688	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	184,191	16.00
16.01	Total program charges (see instructions)(from contractor's records)		231,065	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		32,393	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		25,822	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.)		108,765	16.04
16.05	Total program cost (see instructions)	0	134,587	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,413	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,156	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		134,587	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		134,587	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)		134,587	26.00
26.01	Sequestration adjustment (see instructions)		2,692	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		150,226	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)		-18,331	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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/14/2024 10:45 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)		2,269,554	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		7,434	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,262,120	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,399	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)		6,399	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		353.51	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	461.27	478.80	8.00
9.00	Rate for Program covered visits (see instructions)	353.51	353.51	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	31	93	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	10,959	32,876	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	43,835	16.00
16.01	Total program charges (see instructions)(from contractor's records)		31,802	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,739	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,397	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.)		32,060	16.04
16.05	Total program cost (see instructions)	0	34,457	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,363	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,740	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		34,457	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		140	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		34,597	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)		34,597	26.00
26.01	Sequestration adjustment (see instructions)		692	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		30,961	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		2,944	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: 15-1315 Component CCN: 15-8570	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/14/2024 10:45 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)		1,298,869	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		20,054	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,278,815	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,824	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)		6,824	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		187.40	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	24	357	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	2,712	44,982	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	47,694	16.00
16.01	Total program charges (see instructions)(from contractor's records)		85,061	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,593	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		893	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.)		36,343	16.04
16.05	Total program cost (see instructions)	0	37,236	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,372	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,420	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		37,236	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,787	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		48,023	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)		48,023	26.00
26.01	Sequestration adjustment (see instructions)		960	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		36,743	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,320	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: 15-1315 Component CCN: 15-8571	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/14/2024 10:45 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)			389,427	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			4,356	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			385,071	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,701	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,701	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			226.38	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	504		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	504		16.00
16.01	Total program charges (see instructions)(from contractor's records)		973		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		403		16.04
16.05	Total program cost (see instructions)	0	403		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		195		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		403		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,128		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,531		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		3,531		26.00
26.01	Sequestration adjustment (see instructions)		71		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		395		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,065		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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/14/2024 10:45 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)	1,166,558	1,166,558	1,166,558	1,166,558	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000159	0.001763	0.000257	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	185	2,057	300	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,309	17,818	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,494	19,875	300	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,212,535	1,212,535	1,212,535	1,212,535	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	892,396	892,396	892,396	892,396	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006180	0.016391	0.000247	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,515	14,627	220	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13,009	34,502	520	0	10.00
11.00	Total number of injections/infusions (from your records)	39	433	63	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	333.56	79.68	8.25	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	36	323	44	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)	12,008	25,737	363	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)		48,031	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)		38,108	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/14/2024 10:45 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)	1,487,433	1,487,433	1,487,433	1,487,433	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000403	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	599	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	4,362	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,961	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,514,568	1,514,568	1,514,568	1,514,568	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	754,986	754,986	754,986	754,986	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003276	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,473	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	7,434	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	106	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	70.13	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	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	140	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)		7,434	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)		140	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/14/2024 10:45 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)	745,909	745,909	745,909	745,909	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000188	0.000671	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	140	501	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,372	4,979	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,512	5,480	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	776,726	776,726	776,726	776,726	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	522,143	522,143	522,143	522,143	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008384	0.007055	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,378	3,684	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10,890	9,164	0	0	10.00
11.00	Total number of injections/infusions (from your records)	34	121	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	320.29	75.74	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	79	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)	4,804	5,983	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)		20,054
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,787

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/14/2024 10:45 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)	211,115	211,115	211,115	211,115	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000022	0.001091	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5	230	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	187	2,016	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	192	2,246	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	217,932	217,932	217,932	217,932	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	171,495	171,495	171,495	171,495	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000881	0.010306	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	151	1,767	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	343	4,013	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	49	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	343.00	81.90	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	34	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)	343	2,785	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)		4,356	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		3,128	16.00

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

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/14/2024 10:45 am

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		211,105	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)		211,105	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		8,648	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		219,753	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8545	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 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		150,226	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)		150,226	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		18,331	6.02
7.00	Total Medicare program liability (see instructions)		131,895	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8546	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 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		30,961	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)		30,961	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,944	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		33,905	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8570	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 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		36,743	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)		36,743	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		10,320	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,063	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: 15-1315 Component CCN: 15-8571	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 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		395	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)		395	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		3,065	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,460	7.00

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