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: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 9:20 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 9:20 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 DAVIESS COMMUNITY HOSPITAL (15-0061) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	253,207	1,132	0	0	1.00
2.00	SUBPROVIDER - IPF	0	6,004	0		0	2.00
3.00	SUBPROVIDER - IRF	0	34,728	0		0	3.00
5.00	SWING BED - SNF	0	0	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		1,812		0	10.00
10.01	RURAL HEALTH CLINIC II	0		693		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-16,082		0	10.02
10.04	RURAL HEALTH CLINIC V	0		100		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		2,937		0	10.05
200.00	TOTAL	0	293,939	-9,408	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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 9:20 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1314 E. WALNUT STREET	PO Box: 760			1.00
2.00	City: WASHINGTON	State: IN	Zip Code: 47501	County: DAVIESS	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	DAVIESS COMMUNITY HOSPITAL	150061	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	DCH - PSYCH	15S061	99915	4	01/01/2003	N	P	O	4.00
5.00	Subprovider - IRF	DCH - REHAB	15T061	99915	5	01/01/2000	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DAVIESS COMMUNITY HOSPITAL	15U061	99915		11/10/1999	N	P	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	HELPING HEART HOSPICE	151553	99915		07/11/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY HOSPITAL MC	158500	99915		12/17/2003	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	NORTH DAVIESS MEDICAL CENTER	153999	99915		12/17/2003	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	DCH HEALTH PAVILION	158501	99915		03/30/2004	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV									15.03
15.04	Hospital-Based Health Clinic - RHC V	GRAND AVENUE PEDIATRICS	158503	99915		01/27/2005	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	8		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 9:20 am

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		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.	191	45	0	0	891	76	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	17	0	0	80		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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 9:20 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 9:20 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 9:20 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 9:20 am

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 9:20 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	215,583	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 9:20 am

		1.00	2.00	
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 9:20 am

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

		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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 9:20 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2024	Y	04/04/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 9:20 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.383.4000	KERRY.BEJARANO@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 9:20 am

		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.	DIRECTOR		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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2024 9:20 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	37	13,505	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	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
25.10	CMHC - CORF	99.10				0	25.10
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
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 9:20 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)	590	89	1,869			1.00
2.00	HMO and other (see instructions)	358	936				2.00
3.00	HMO IPF Subprovider	112	0				3.00
4.00	HMO IRF Subprovider	61	97				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	590	89	1,869			7.00
8.00	INTENSIVE CARE UNIT	238	24	574			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		78	886			13.00
14.00	Total (see instructions)	828	191	3,329	0.00	372.67	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	3,064	0	3,864	0.00	27.68	16.00
17.00	SUBPROVIDER - IRF	1,119	0	1,344	0.00	12.41	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	2,984	9	3,812	0.00	3.34	24.00
24.10	HOSPICE (non-distinct part)			25			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	938	0	6,102	0.00	7.80	26.00
26.01	RURAL HEALTH CLINIC II	483	0	2,803	0.00	6.17	26.01
26.02	RURAL HEALTH CLINIC III	1,312	0	14,937	0.00	13.90	26.02
26.04	RURAL HEALTH CLINIC V	6	0	6,188	0.00	11.53	26.04
26.05	RURAL HEALTH CLINIC VI	971	0	4,704	0.00	6.73	26.05
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	462.23	27.00
28.00	Observation Bed Days		293	1,486			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			48			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	76	149			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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 9:20 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	285	22	950	1.00
2.00	HMO and other (see instructions)			117	232		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	285	22	950	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	143	13	183	16.00
17.00	SUBPROVIDER - IRF	0.00	0	86	0	104	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
25.10	CMHC - CORF	0.00					25.10
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
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
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 WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2024 9:20 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,453,265	0	31,453,265	962,781.00	32.67	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		30,000	0	30,000	185.00	162.16	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,774,542	0	1,774,542	11,239.00	157.89	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,325,503	0	2,325,503	85,572.00	27.18	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,234,532	-14,058	8,220,474	255,548.00	32.17	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		968,761	0	968,761	7,259.00	133.46	11.00
12.00	Contract labor: Top level management and other management and administrative services		591,115	0	591,115	4,160.00	142.09	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,972,818	0	3,972,818			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,683,820	0	1,683,820			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		3,412	0	3,412			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		202,842	0	202,842			23.00
24.00	Wage-related costs (RHC/FQHC)		524,904	0	524,904			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2024 9:20 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	208,016	0	208,016	6,520.00	31.90	26.00
27.00	Administrative & General	5.00	2,290,235	-45,892	2,244,343	92,619.00	24.23	27.00
28.00	Administrative & General under contract (see inst.)		259,705	0	259,705	1,086.00	239.14	28.00
29.00	Maintenance & Repairs	6.00	69,152	0	69,152	2,080.00	33.25	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	648,520	0	648,520	37,010.00	17.52	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	381,556	-266,273	115,283	6,797.00	16.96	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	219,724	219,724	12,954.00	16.96	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	647,279	0	647,279	19,070.00	33.94	38.00
39.00	Central Services and Supply	14.00	315,594	0	315,594	12,669.00	24.91	39.00
40.00	Pharmacy	15.00	533,822	0	533,822	14,672.00	36.38	40.00
41.00	Medical Records & Medical Records Library	16.00	537,735	0	537,735	22,556.00	23.84	41.00
42.00	Social Service	17.00	0	261,060	261,060	8,730.00	29.90	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2024 9:20 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		27,612,925	0	27,612,925	867,056.00	31.85	1.00
2.00	Excluded area salaries (see instructions)		8,234,532	-14,058	8,220,474	255,548.00	32.17	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19,378,393	14,058	19,392,451	611,508.00	31.71	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,559,876	0	1,559,876	11,419.00	136.60	4.00
5.00	Subtotal wage-related costs (see inst.)		3,976,230	0	3,976,230	0.00	20.50	5.00
6.00	Total (sum of lines 3 thru 5)		24,914,499	14,058	24,928,557	622,927.00	40.02	6.00
7.00	Total overhead cost (see instructions)		5,891,614	168,619	6,060,233	236,763.00	25.60	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2024 9:20 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	536,912	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	13,254	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,369,378	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,764	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	54,067	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	117,491	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	2,259,055	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	20,875	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,387,796	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/31/2024 9:20 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 9:20 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1402 GRAND AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 9:20 am
		RHC I	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 9:20 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			202 NORTH WEST STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ODON		IN	47562	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0061 Component CCN: 15-3999	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 9:20 am
		RHC II	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 9:20 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1805 S. STATE RD. 57		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8501

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

Worksheet S-8

Date/Time Prepared:
5/31/2024 9:20 am

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 9:20 am

RHC V | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1400 GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0061 Component CCN: 15-8503	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 9:20 am
		RHC V	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 9:20 am

RHC VI | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			12546 E US HWY 50		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0061 Component CCN: 15-8506	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 9:20 am
		RHC VI	Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/31/2024 9:20 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	2,971	0	0	2,971	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	22	0	0	22	13.00
14.00	Total Hospice Days	2,993	0	0	2,993	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 9:20 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)	0.373829	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,806,315	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	45,239,183	6.00
7.00	Medicaid cost (line 1 times line 6)	16,911,719	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	15,105,404	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)	15,105,404	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)	1,025,672	59,242	1,084,914	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	383,426	59,242	442,668	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)	383,426	59,242	442,668	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)	4,357,681	26.00
27.00	Medicare reimbursable bad debts (see instructions)	96,042	27.00
27.01	Medicare allowable bad debts (see instructions)	147,756	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,209,925	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,625,506	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,068,174	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,173,578	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 9:20 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.322540	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)	1,025,672	59,242	1,084,914	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	330,820	59,242	390,062	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)	330,820	59,242	390,062	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)	4,357,681	26.00
27.00	Medicare reimbursable bad debts (see instructions)	85,232	27.00
27.01	Medicare allowable bad debts (see instructions)	131,126	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,226,555	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,409,127	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,799,189	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,799,189	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 9:20 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		2,294,081	2,294,081	183,175	2,477,256	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,414,398	1,414,398	11,961	1,426,359	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	208,016	6,478,781	6,686,797	-61,349	6,625,448	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,290,235	14,229,641	16,519,876	-1,165,616	15,354,260	5.00
6.00	00600	MAINTENANCE & REPAIRS	69,152	2,285,058	2,354,210	0	2,354,210	6.00
7.00	00700	OPERATION OF PLANT	0	813,890	813,890	0	813,890	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,274	125,274	0	125,274	8.00
9.00	00900	HOUSEKEEPING	648,520	127,005	775,525	0	775,525	9.00
10.00	01000	DIETARY	381,556	347,134	728,690	-508,523	220,167	10.00
11.00	01100	CAFETERIA	0	0	0	419,625	419,625	11.00
13.00	01300	NURSING ADMINISTRATION	647,279	36,305	683,584	0	683,584	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	315,594	88,133	403,727	0	403,727	14.00
15.00	01500	PHARMACY	533,822	166,214	700,036	0	700,036	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537,735	134,347	672,082	0	672,082	16.00
17.00	01700	SOCIAL SERVICE	0	135	135	261,060	261,195	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,535,142	324,195	2,859,337	-104,380	2,754,957	30.00
31.00	03100	INTENSIVE CARE UNIT	863,469	32,829	896,298	-80,052	816,246	31.00
40.00	04000	SUBPROVIDER - IPF	1,982,747	176,304	2,159,051	-80,665	2,078,386	40.00
41.00	04100	SUBPROVIDER - IRF	843,661	106,590	950,251	6,986	957,237	41.00
43.00	04300	NURSERY	0	35,762	35,762	526,897	562,659	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,124,970	1,605,847	3,730,817	0	3,730,817	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168,775	0	168,775	388,301	557,076	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	946,110	370,711	1,316,821	0	1,316,821	54.00
56.00	05600	RADIOISOTOPE	267,978	664,099	932,077	0	932,077	56.00
60.00	06000	LABORATORY	961,936	1,496,271	2,458,207	0	2,458,207	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	3,599	3,599	0	3,599	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	590,505	158,764	749,269	0	749,269	65.00
66.00	06600	PHYSICAL THERAPY	1,107,797	61,470	1,169,267	0	1,169,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	425,059	3,646	428,705	0	428,705	67.00
68.00	06800	SPEECH PATHOLOGY	193,317	66	193,383	0	193,383	68.00
69.00	06900	ELECTROCARDIOLOGY	64,610	14,398	79,008	0	79,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,869,904	2,869,904	-558,603	2,311,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	558,603	558,603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,135,306	4,135,306	0	4,135,306	73.00
76.00	03020	CARDIAC REHAB	118,917	14,195	133,112	0	133,112	76.00
76.01	03030	ADDICTION SERVICES	235,638	62,527	298,165	0	298,165	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	745,107	79,750	824,857	0	824,857	88.00
88.01	08801	RURAL HEALTH CLINIC II	558,723	70,941	629,664	0	629,664	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,047,579	181,021	1,228,600	0	1,228,600	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,641,569	190,905	1,832,474	0	1,832,474	88.04
88.05	08804	RURAL HEALTH CLINIC VI	550,161	53,918	604,079	0	604,079	88.05
90.00	09000	CLINIC	219,102	263,134	482,236	0	482,236	90.00
90.01	09001	ONCOLOGY	297,088	14,651	311,739	0	311,739	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,434,578	3,370,761	4,805,339	-21,747	4,783,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	488,694	241,351	730,045	-112,980	617,065	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,335,202	505,193	2,840,395	0	2,840,395	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		173,893	173,893	0	173,893	113.00
116.00	11600	HOSPICE	239,061	169,090	408,151	0	408,151	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,619,404	45,991,487	74,610,891	-337,307	74,273,584	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	2,833,861	1,273,723	4,107,584	337,307	4,444,891	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	31,453,265	47,265,210	78,718,475	0	78,718,475	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 9:20 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	0	2,477,256		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,426,359		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-134,552	6,490,896		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,470,628	7,883,632		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,354,210		6.00
7.00	00700	OPERATION OF PLANT	0	813,890		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,274		8.00
9.00	00900	HOUSEKEEPING	0	775,525		9.00
10.00	01000	DIETARY	0	220,167		10.00
11.00	01100	CAFETERIA	-162,974	256,651		11.00
13.00	01300	NURSING ADMINISTRATION	0	683,584		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4,736	398,991		14.00
15.00	01500	PHARMACY	-5,445	694,591		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,880	666,202		16.00
17.00	01700	SOCIAL SERVICE	0	261,195		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-850,050	1,904,907		30.00
31.00	03100	INTENSIVE CARE UNIT	0	816,246		31.00
40.00	04000	SUBPROVIDER - IPF	-390,800	1,687,586		40.00
41.00	04100	SUBPROVIDER - IRF	-169,858	787,379		41.00
43.00	04300	NURSERY	0	562,659		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,233,656	2,497,161		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	557,076		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-172,642	1,144,179		54.00
56.00	05600	RADIOISOTOPE	-440	931,637		56.00
60.00	06000	LABORATORY	-30,000	2,428,207		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	3,599		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-60,336	688,933		65.00
66.00	06600	PHYSICAL THERAPY	0	1,169,267		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	428,705		67.00
68.00	06800	SPEECH PATHOLOGY	0	193,383		68.00
69.00	06900	ELECTROCARDIOLOGY	-11,076	67,932		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,311,301		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	558,603		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,135,306		73.00
76.00	03020	CARDIAC REHAB	0	133,112		76.00
76.01	03030	ADDICTION SERVICES	0	298,165		76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	824,857		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	629,664		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,228,600		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08803	RURAL HEALTH CLINIC V	0	1,832,474		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	604,079		88.05
90.00	09000	CLINIC	-2,250	479,986		90.00
90.01	09001	ONCOLOGY	0	311,739		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	-8,608	4,774,984		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	-214,598	402,467		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,840,395		95.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-173,893	0		113.00
116.00	11600	HOSPICE	0	408,151		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,102,422	63,171,162		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	4,444,891		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,102,422	67,616,053		200.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 9:20 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY				
1.00	CAFETERIA	11.00	219,724	199,901	1.00
2.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	46,549	42,349	2.00
	TOTALS		266,273	242,250	
	C - BILLING COSTS				
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	13,072	19,754	1.00
	TOTALS		13,072	19,754	
	D - OBSTETRICS				
1.00	NURSERY	43.00	489,076	37,821	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	360,429	27,872	2.00
	TOTALS		849,505	65,693	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,175	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,961	2.00
3.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	0	215,583	3.00
	TOTALS		0	410,719	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	558,603	1.00
	TOTALS		0	558,603	
	G - SOCIAL SERVICES RECLASS				
1.00	SOCIAL SERVICE	17.00	261,060	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		261,060	0	
	H - OTHER				
1.00	ADULTS & PEDIATRICS	30.00	62,875	0	1.00
2.00	SUBPROVIDER - IPF	40.00	6,986	0	2.00
3.00	SUBPROVIDER - IRF	41.00	6,986	0	3.00
	TOTALS		76,847	0	
	I - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	750,600	1.00
	TOTALS		0	750,600	
	J - BENEFIT RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,349	1.00
	TOTALS		0	61,349	
500.00	Grand Total: Increases		1,466,757	2,108,968	500.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 9:20 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY						
1.00	DIETARY	10.00	266,273	242,250	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		266,273	242,250			
	C - BILLING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	13,072	19,754	0		1.00
	TOTALS		13,072	19,754			
	D - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	849,505	65,693	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		849,505	65,693			
	E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	410,719	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	410,719			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	558,603	0		1.00
	TOTALS		0	558,603			
	G - SOCIAL SERVICES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	32,820	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	2,657	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	3,205	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	87,651	0	0		4.00
5.00	EMERGENCY	91.00	21,747	0	0		5.00
6.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	112,980	0	0		6.00
	TOTALS		261,060	0			
	H - OTHER						
1.00	INTENSIVE CARE UNIT	31.00	76,847	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		76,847	0			
	I - HOSPITALIST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	750,600	0		1.00
	TOTALS		0	750,600			
	J - BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	61,349	0		1.00
	TOTALS		0	61,349			
500.00	Grand Total: Decreases		1,466,757	2,108,968			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 9:20 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	1,280,955	0	0	0	0	1.00
2.00	Land Improvements	687,865	0	0	0	0	2.00
3.00	Buildings and Fixtures	43,751,153	1,757,920	0	1,757,920	0	3.00
4.00	Building Improvements	39,119	0	0	0	0	4.00
5.00	Fixed Equipment	11,696,061	1,069,135	0	1,069,135	0	5.00
6.00	Movable Equipment	32,925,492	0	0	0	402,750	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	90,380,645	2,827,055	0	2,827,055	402,750	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	90,380,645	2,827,055	0	2,827,055	402,750	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,280,955	0	1.00
2.00	Land Improvements	687,865	0	2.00
3.00	Buildings and Fixtures	45,509,073	0	3.00
4.00	Building Improvements	39,119	0	4.00
5.00	Fixed Equipment	12,765,196	0	5.00
6.00	Movable Equipment	32,522,742	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,804,950	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	92,804,950	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2024 9:20 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	2,070,571	0	223,510	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,015,049	321,712	0	0	77,637	2.00
3.00	Total (sum of lines 1-2)	3,085,620	321,712	223,510	0	77,637	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	2,294,081		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,414,398		2.00
3.00	Total (sum of lines 1-2)	0	3,708,479		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2024 9:20 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	60,282,208	0	60,282,208	0.649558	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,522,742	0	32,522,742	0.350442	0	2.00
3.00	Total (sum of lines 1-2)	92,804,950	0	92,804,950	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,070,571	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,015,049	321,712	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,085,620	321,712	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	223,510	183,175	0	0	2,477,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,961	77,637	0	1,426,359	2.00
3.00	Total (sum of lines 1-2)	223,510	195,136	77,637	0	3,903,615	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 9:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4,736	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,725	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-23,760	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,135,706			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-162,974	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-5,445	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,880	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	A	-2,578	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 9:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSES	A	-310,668	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT EXPENSES	A	-303,351	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.01	NON-ALLOWABLE COSTS	A	-4,107	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.04	PHYSICIAN BENEFITS	A	-134,552	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.04
36.00	CPR CLASS INCOME	B	-8,608	EMERGENCY	91.00	0	36.00
36.01	MISC. INCOME	B	-482,404	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	INTEREST EXPENSE OFFSET	A	-173,893	INTEREST EXPENSE	113.00	0	36.02
38.00	LOBBYING EXPENSE	A	-9,728	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DEBT ISSUANCE COST AMORTIZATION	A	21,245	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-6,353,552	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,102,422				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 9:20 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	850,050	850,050	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	390,800	390,800	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	169,858	169,858	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	1,233,656	1,233,656	0	246,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	172,642	172,642	0	271,900	0	5.00
6.00	56.00	RADIOISOTOPE	440	440	0	271,900	0	6.00
7.00	60.00	LABORATORY	30,000	30,000	0	260,300	0	7.00
8.00	65.00	RESPIRATORY THERAPY	60,336	60,336	0	260,300	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	11,076	11,076	0	211,500	0	9.00
10.00	90.00	CLINIC	2,250	2,250	0	211,500	0	10.00
11.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	214,598	214,598	0	211,500	0	11.00
200.00			3,135,706	3,135,706	0		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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	11.00
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	850,050		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	390,800		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	169,858		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,233,656		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	172,642		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	440		6.00
7.00	60.00	LABORATORY	0	0	0	30,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	60,336		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	11,076		9.00
10.00	90.00	CLINIC	0	0	0	2,250		10.00
11.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	214,598		11.00
200.00			0	0	0	3,135,706		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 9:20 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	2,477,256	2,477,256				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,426,359		1,426,359			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,490,896	6,057	556	6,497,509		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,883,632	135,798	151,562	466,716	8,637,708	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,354,210	66,371	8,869	14,380	2,443,830	6.00
7.00	00700	OPERATION OF PLANT	813,890	478,654	0	0	1,292,544	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,274	5,152	0	0	130,426	8.00
9.00	00900	HOUSEKEEPING	775,525	17,056	1,870	134,861	929,312	9.00
10.00	01000	DIETARY	220,167	44,725	7,789	23,973	296,654	10.00
11.00	01100	CAFETERIA	256,651	16,383	0	45,692	318,726	11.00
13.00	01300	NURSING ADMINISTRATION	683,584	32,910	17,097	134,603	868,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	398,991	49,480	46,846	65,628	560,945	14.00
15.00	01500	PHARMACY	694,591	20,024	13,943	111,009	839,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	666,202	109,199	3,434	111,823	890,658	16.00
17.00	01700	SOCIAL SERVICE	261,195	0	0	54,288	315,483	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,904,907	104,510	99,900	363,054	2,472,371	30.00
31.00	03100	INTENSIVE CARE UNIT	816,246	26,379	24,332	162,913	1,029,870	31.00
40.00	04000	SUBPROVIDER - IPF	1,687,586	108,581	18,632	395,542	2,210,341	40.00
41.00	04100	SUBPROVIDER - IRF	787,379	95,695	7,462	176,894	1,067,430	41.00
43.00	04300	NURSERY	562,659	10,503	0	101,704	674,866	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,497,161	149,578	218,438	441,892	3,307,069	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	557,076	108,736	0	110,049	775,861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,179	134,221	108,588	196,745	1,583,733	54.00
56.00	05600	RADIOISOTOPE	931,637	12,555	49,387	55,727	1,049,306	56.00
60.00	06000	LABORATORY	2,428,207	37,576	127,237	200,037	2,793,057	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,599	2,195	0	0	5,794	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	688,933	28,872	71,343	122,797	911,945	65.00
66.00	06600	PHYSICAL THERAPY	1,169,267	74,414	88,333	230,369	1,562,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	428,705	15,854	18,640	88,392	551,591	67.00
68.00	06800	SPEECH PATHOLOGY	193,383	11,231	13,556	40,201	258,371	68.00
69.00	06900	ELECTROCARDIOLOGY	67,932	6,840	2,641	13,436	90,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,311,301	0	513	0	2,311,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	558,603	0	0	0	558,603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,135,306	3,541	0	0	4,138,847	73.00
76.00	03020	CARDIAC REHAB	133,112	25,364	0	24,729	183,205	76.00
76.01	03030	ADDICTION SERVICES	298,165	0	0	49,001	347,166	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	824,857	53,673	3,429	154,946	1,036,905	88.00
88.01	08801	RURAL HEALTH CLINIC II	629,664	38,437	978	116,188	785,267	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,228,600	59,079	6,709	217,846	1,512,234	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,832,474	21,425	4,568	341,368	2,199,835	88.04
88.05	08804	RURAL HEALTH CLINIC VI	604,079	28,144	671	114,407	747,301	88.05
90.00	09000	CLINIC	479,986	41,471	1,740	45,563	568,760	90.00
90.01	09001	ONCOLOGY	311,739	42,530	0	61,780	416,049	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,774,984	71,159	52,556	293,801	5,192,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	402,467	64,363	91	78,130	545,051	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,840,395	0	188,505	485,610	3,514,510	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	408,151	6,454	0	49,713	464,318	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,171,162	2,365,189	1,360,215	5,895,807	62,391,249	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	4,444,891	112,067	66,144	601,702	5,224,804	194.00
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 9:20 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	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	67,616,053	2,477,256	1,426,359	6,497,509	67,616,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	8,637,708					5.00
6.00	00600	MAINTENANCE & REPAIRS	357,914	2,801,744				6.00
7.00	00700	OPERATION OF PLANT	189,301	591,029	2,072,874			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,102	6,362	5,965	161,855		8.00
9.00	00900	HOUSEKEEPING	136,103	21,061	19,747	42,861	1,149,084	9.00
10.00	01000	DIETARY	43,447	55,226	51,783	879	29,066	10.00
11.00	01100	CAFETERIA	46,679	20,230	18,968	0	10,647	11.00
13.00	01300	NURSING ADMINISTRATION	127,152	40,636	38,102	0	21,387	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,154	61,097	57,288	0	32,156	14.00
15.00	01500	PHARMACY	122,960	24,725	23,183	0	13,013	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,442	134,836	126,429	0	70,965	16.00
17.00	01700	SOCIAL SERVICE	46,204	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	362,094	129,047	121,001	30,776	67,918	30.00
31.00	03100	INTENSIVE CARE UNIT	150,831	32,572	30,541	4,396	17,143	31.00
40.00	04000	SUBPROVIDER - IPF	323,718	134,074	125,714	0	70,564	40.00
41.00	04100	SUBPROVIDER - IRF	156,332	118,162	110,795	5,276	62,190	41.00
43.00	04300	NURSERY	98,838	12,969	12,160	0	6,826	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	484,340	184,695	173,179	14,068	97,207	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,629	134,264	125,893	0	70,664	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,947	165,732	155,399	3,250	87,226	54.00
56.00	05600	RADIOISOTOPE	153,677	15,503	14,536	0	8,159	56.00
60.00	06000	LABORATORY	409,060	46,399	43,506	0	24,420	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	849	2,711	2,542	0	1,427	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	133,560	35,650	33,427	879	18,763	65.00
66.00	06600	PHYSICAL THERAPY	228,820	91,884	86,155	11,787	48,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,784	19,576	18,355	2,511	10,303	67.00
68.00	06800	SPEECH PATHOLOGY	37,840	13,868	13,003	1,779	7,299	68.00
69.00	06900	ELECTROCARDIOLOGY	13,305	8,446	7,919	0	4,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	338,579	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,811	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	606,159	4,373	4,100	0	2,301	73.00
76.00	03020	CARDIAC REHAB	26,831	31,318	29,366	0	16,483	76.00
76.01	03030	ADDICTION SERVICES	50,845	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	151,861	66,274	62,142	5,729	34,880	88.00
88.01	08801	RURAL HEALTH CLINIC II	115,007	47,461	44,502	0	24,979	88.01
88.02	08802	RURAL HEALTH CLINIC III	221,476	72,949	68,401	0	38,394	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	322,179	26,455	24,806	372	13,924	88.04
88.05	08804	RURAL HEALTH CLINIC VI	109,447	34,751	32,584	0	18,290	88.05
90.00	09000	CLINIC	83,298	51,207	48,014	934	26,951	90.00
90.01	09001	ONCOLOGY	60,933	52,515	49,241	2,638	27,639	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	760,473	87,866	82,387	7,914	46,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	79,826	79,474	74,519	12,311	41,828	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	514,721	0	0	3,517	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	68,002	7,969	7,472	0	4,194	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,872,530	2,663,366	1,943,124	151,877	1,076,254	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	765,178	138,378	129,750	9,978	72,830	194.00
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)	8,637,708	2,801,744	2,072,874	161,855	1,149,084	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	477,055					10.00
11.00	01100	CAFETERIA	0	415,250				11.00
13.00	01300	NURSING ADMINISTRATION	0	9,856	1,105,327			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,548	0	800,188		14.00
15.00	01500	PHARMACY	0	7,583	0	759	1,031,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,658	0	5	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,512	0	17	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	163,209	29,948	174,016	11,166	0	30.00
31.00	03100	INTENSIVE CARE UNIT	55,596	11,106	64,533	2,038	0	31.00
40.00	04000	SUBPROVIDER - IPF	191,898	29,754	172,891	2,678	0	40.00
41.00	04100	SUBPROVIDER - IRF	66,352	13,339	77,507	1,349	0	41.00
43.00	04300	NURSERY	0	6,555	38,091	6,206	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,390	135,911	18,941	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,133	53,071	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,059	75,882	7,297	0	54.00
56.00	05600	RADIOISOTOPE	0	3,046	17,697	2,785	0	56.00
60.00	06000	LABORATORY	0	20,418	118,643	219,277	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,499	0	9,565	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,401	0	409	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,285	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,274	0	1	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	893	0	490	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	401,157	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,954	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,031,790	73.00
76.00	03020	CARDIAC REHAB	0	1,554	9,027	533	0	76.00
76.01	03030	ADDICTION SERVICES	0	4,706	27,346	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,390	0	400	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,633	0	481	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	14,939	0	1,552	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	12,397	0	1,056	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	7,239	0	429	0	88.05
90.00	09000	CLINIC	0	3,426	0	1,171	0	90.00
90.01	09001	ONCOLOGY	0	5,090	0	968	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	20,626	119,847	5,226	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	6,014	0	41	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	42,967	0	5,067	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,591	20,865	921	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	477,055	372,829	1,105,327	798,939	1,031,790	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	42,421	0	1,249	0	194.00
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)	477,055	415,250	1,105,327	800,188	1,031,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,364,993					16.00
17.00	01700	SOCIAL SERVICE	0	366,216				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,998	4,350	3,617,894	0	3,617,894	30.00
31.00	03100	INTENSIVE CARE UNIT	10,644	5,019	1,414,289	0	1,414,289	31.00
40.00	04000	SUBPROVIDER - IPF	53,552	124,526	3,439,710	0	3,439,710	40.00
41.00	04100	SUBPROVIDER - IRF	16,676	0	1,695,408	0	1,695,408	41.00
43.00	04300	NURSERY	9,707	0	866,218	0	866,218	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	115,482	0	4,554,282	0	4,554,282	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,815	0	1,292,330	0	1,292,330	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,620	0	2,519,145	0	2,519,145	54.00
56.00	05600	RADIOISOTOPE	50,821	0	1,315,530	0	1,315,530	56.00
60.00	06000	LABORATORY	166,155	0	3,840,935	0	3,840,935	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	4,854	0	18,177	0	18,177	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,907	0	1,191,195	0	1,191,195	65.00
66.00	06600	PHYSICAL THERAPY	54,297	0	2,101,495	0	2,101,495	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,594	0	715,999	0	715,999	67.00
68.00	06800	SPEECH PATHOLOGY	7,234	0	341,669	0	341,669	68.00
69.00	06900	ELECTROCARDIOLOGY	8,679	0	135,026	0	135,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71,642	0	3,123,192	0	3,123,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,935	0	752,303	0	752,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,576	0	5,938,146	0	5,938,146	73.00
76.00	03020	CARDIAC REHAB	4,086	0	302,403	0	302,403	76.00
76.01	03030	ADDICTION SERVICES	676	0	430,739	0	430,739	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,889	0	1,376,470	0	1,376,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,209	0	1,028,539	0	1,028,539	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,481	0	1,950,426	0	1,950,426	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	17,404	0	2,618,428	0	2,618,428	88.04
88.05	08804	RURAL HEALTH CLINIC VI	6,596	0	956,637	0	956,637	88.05
90.00	09000	CLINIC	17,859	0	801,620	0	801,620	90.00
90.01	09001	ONCOLOGY	9,486	0	624,559	0	624,559	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	160,408	31,406	6,514,897	0	6,514,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	7,473	200,915	1,047,452	0	1,047,452	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	41,425	0	4,122,207	0	4,122,207	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,813	0	584,145	0	584,145	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,364,993	366,216	61,231,465	0	61,231,465	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	6,384,588	0	6,384,588	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,364,993	366,216	67,616,053	0	67,616,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 9:20 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	6,057	556	6,613	6,613	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	135,798	151,562	287,360	476	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	66,371	8,869	75,240	15	6.00
7.00	00700	OPERATION OF PLANT	0	478,654	0	478,654	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,152	0	5,152	0	8.00
9.00	00900	HOUSEKEEPING	0	17,056	1,870	18,926	137	9.00
10.00	01000	DIETARY	0	44,725	7,789	52,514	24	10.00
11.00	01100	CAFETERIA	0	16,383	0	16,383	47	11.00
13.00	01300	NURSING ADMINISTRATION	0	32,910	17,097	50,007	137	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	49,480	46,846	96,326	67	14.00
15.00	01500	PHARMACY	0	20,024	13,943	33,967	113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	109,199	3,434	112,633	114	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	55	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	104,510	99,900	204,410	370	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,379	24,332	50,711	166	31.00
40.00	04000	SUBPROVIDER - IPF	0	108,581	18,632	127,213	403	40.00
41.00	04100	SUBPROVIDER - IRF	0	95,695	7,462	103,157	180	41.00
43.00	04300	NURSERY	0	10,503	0	10,503	104	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	149,578	218,438	368,016	450	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	108,736	0	108,736	112	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	134,221	108,588	242,809	201	54.00
56.00	05600	RADIOISOTOPE	0	12,555	49,387	61,942	57	56.00
60.00	06000	LABORATORY	0	37,576	127,237	164,813	204	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	2,195	0	2,195	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,872	71,343	100,215	125	65.00
66.00	06600	PHYSICAL THERAPY	0	74,414	88,333	162,747	235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,854	18,640	34,494	90	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,231	13,556	24,787	41	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,840	2,641	9,481	14	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	513	513	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	3,541	0	3,541	0	73.00
76.00	03020	CARDIAC REHAB	0	25,364	0	25,364	25	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	50	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	53,673	3,429	57,102	158	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	38,437	978	39,415	118	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	59,079	6,709	65,788	222	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	21,425	4,568	25,993	348	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	28,144	671	28,815	117	88.05
90.00	09000	CLINIC	0	41,471	1,740	43,211	46	90.00
90.01	09001	ONCOLOGY	0	42,530	0	42,530	63	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	71,159	52,556	123,715	300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	64,363	91	64,454	80	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	188,505	188,505	495	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	6,454	0	6,454	51	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,365,189	1,360,215	3,725,404	6,010	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	112,067	66,144	178,211	603	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 9:20 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	
202.00	TOTAL (sum lines 118 through 201)	0	2,477,256	1,426,359	3,903,615	6,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	287,836					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,926	87,181				6.00
7.00	00700	OPERATION OF PLANT	6,308	18,392	503,354			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	636	198	1,448	7,434		8.00
9.00	00900	HOUSEKEEPING	4,535	655	4,795	1,970	31,018	9.00
10.00	01000	DIETARY	1,448	1,718	12,574	40	785	10.00
11.00	01100	CAFETERIA	1,555	629	4,606	0	287	11.00
13.00	01300	NURSING ADMINISTRATION	4,237	1,264	9,252	0	577	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,737	1,901	13,911	0	868	14.00
15.00	01500	PHARMACY	4,097	769	5,630	0	351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,346	4,196	30,701	0	1,916	16.00
17.00	01700	SOCIAL SERVICE	1,540	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,065	4,016	29,382	1,414	1,833	30.00
31.00	03100	INTENSIVE CARE UNIT	5,026	1,014	7,416	202	463	31.00
40.00	04000	SUBPROVIDER - IPF	10,786	4,172	30,527	0	1,905	40.00
41.00	04100	SUBPROVIDER - IRF	5,209	3,677	26,904	242	1,679	41.00
43.00	04300	NURSERY	3,293	404	2,953	0	184	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,138	5,747	42,056	646	2,625	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,786	4,178	30,570	0	1,907	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,729	5,157	37,735	149	2,355	54.00
56.00	05600	RADIOISOTOPE	5,121	482	3,530	0	220	56.00
60.00	06000	LABORATORY	13,630	1,444	10,564	0	659	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	28	84	617	0	39	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,450	1,109	8,117	40	506	65.00
66.00	06600	PHYSICAL THERAPY	7,624	2,859	20,921	541	1,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,692	609	4,457	115	278	67.00
68.00	06800	SPEECH PATHOLOGY	1,261	432	3,158	82	197	68.00
69.00	06900	ELECTROCARDIOLOGY	443	263	1,923	0	120	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,282	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,726	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,198	136	996	0	62	73.00
76.00	03020	CARDIAC REHAB	894	975	7,131	0	445	76.00
76.01	03030	ADDICTION SERVICES	1,694	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,060	2,062	15,090	263	942	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,832	1,477	10,806	0	674	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,380	2,270	16,610	0	1,036	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	10,735	823	6,024	17	376	88.04
88.05	08804	RURAL HEALTH CLINIC VI	3,647	1,081	7,912	0	494	88.05
90.00	09000	CLINIC	2,776	1,593	11,659	43	728	90.00
90.01	09001	ONCOLOGY	2,030	1,634	11,957	121	746	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	25,339	2,734	20,006	364	1,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	2,660	2,473	18,095	565	1,129	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,151	0	0	162	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,266	248	1,814	0	113	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,316	82,875	471,847	6,976	29,052	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	25,520	4,306	31,507	458	1,966	194.00
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)	287,836	87,181	503,354	7,434	31,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	69,103					10.00
11.00	01100	CAFETERIA	0	23,507				11.00
13.00	01300	NURSING ADMINISTRATION	0	558	66,032			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	371	0	116,181		14.00
15.00	01500	PHARMACY	0	429	0	110	45,466	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	660	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	255	0	2	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,641	1,695	10,397	1,621	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,053	629	3,855	296	0	31.00
40.00	04000	SUBPROVIDER - IPF	27,798	1,684	10,328	389	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,611	755	4,630	196	0	41.00
43.00	04300	NURSERY	0	371	2,276	901	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,324	8,119	2,750	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	517	3,170	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	739	4,533	1,059	0	54.00
56.00	05600	RADIOISOTOPE	0	172	1,057	404	0	56.00
60.00	06000	LABORATORY	0	1,156	7,088	31,837	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	481	0	1,389	0	65.00
66.00	06600	PHYSICAL THERAPY	0	985	0	59	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	356	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	129	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	51	0	71	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	58,248	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,077	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	45,466	73.00
76.00	03020	CARDIAC REHAB	0	88	539	77	0	76.00
76.01	03030	ADDICTION SERVICES	0	266	1,634	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	475	0	58	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	376	0	70	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	846	0	225	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	702	0	153	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	410	0	62	0	88.05
90.00	09000	CLINIC	0	194	0	170	0	90.00
90.01	09001	ONCOLOGY	0	288	0	140	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,168	7,160	759	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	340	0	6	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,433	0	736	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	203	1,246	134	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,103	21,106	66,032	116,000	45,466	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	2,401	0	181	0	194.00
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)	69,103	23,507	66,032	116,181	45,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	154,567					16.00
17.00	01700	SOCIAL SERVICE	0	1,852				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,890	22	296,756	0	296,756	30.00
31.00	03100	INTENSIVE CARE UNIT	1,206	25	79,062	0	79,062	31.00
40.00	04000	SUBPROVIDER - IPF	6,066	630	221,901	0	221,901	40.00
41.00	04100	SUBPROVIDER - IRF	1,889	0	158,129	0	158,129	41.00
43.00	04300	NURSERY	1,100	0	22,089	0	22,089	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,081	0	460,952	0	460,952	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,112	0	154,088	0	154,088	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,108	0	324,574	0	324,574	54.00
56.00	05600	RADIOISOTOPE	5,757	0	78,742	0	78,742	56.00
60.00	06000	LABORATORY	18,821	0	250,216	0	250,216	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	550	0	3,513	0	3,513	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,407	0	120,839	0	120,839	65.00
66.00	06600	PHYSICAL THERAPY	6,150	0	203,426	0	203,426	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,012	0	46,103	0	46,103	67.00
68.00	06800	SPEECH PATHOLOGY	819	0	30,906	0	30,906	68.00
69.00	06900	ELECTROCARDIOLOGY	983	0	13,349	0	13,349	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,115	0	78,158	0	78,158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,692	0	18,495	0	18,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,056	0	87,455	0	87,455	73.00
76.00	03020	CARDIAC REHAB	463	0	36,001	0	36,001	76.00
76.01	03030	ADDICTION SERVICES	77	0	3,721	0	3,721	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,120	0	82,330	0	82,330	88.00
88.01	08801	RURAL HEALTH CLINIC II	477	0	57,245	0	57,245	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,320	0	96,697	0	96,697	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,971	0	47,142	0	47,142	88.04
88.05	08804	RURAL HEALTH CLINIC VI	747	0	43,285	0	43,285	88.05
90.00	09000	CLINIC	2,023	0	62,443	0	62,443	90.00
90.01	09001	ONCOLOGY	1,075	0	60,584	0	60,584	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	18,170	159	201,122	0	201,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	846	1,016	91,664	0	91,664	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,692	0	214,174	0	214,174	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	772	0	13,301	0	13,301	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154,567	1,852	3,658,462	0	3,658,462	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	245,153	0	245,153	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	154,567	1,852	3,903,615	0	3,903,615	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	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	224,543					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,476,741				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	549	576	31,245,249			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,309	156,915	2,244,343	-8,637,708	58,978,345	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,016	9,182	69,152	0	2,443,830	6.00
7.00	00700	OPERATION OF PLANT	43,386	0	0	0	1,292,544	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	0	0	0	130,426	8.00
9.00	00900	HOUSEKEEPING	1,546	1,936	648,520	0	929,312	9.00
10.00	01000	DIETARY	4,054	8,064	115,283	0	296,654	10.00
11.00	01100	CAFETERIA	1,485	0	219,724	0	318,726	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	17,701	647,279	0	868,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	48,501	315,594	0	560,945	14.00
15.00	01500	PHARMACY	1,815	14,435	533,822	0	839,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	3,555	537,735	0	890,658	16.00
17.00	01700	SOCIAL SERVICE	0	0	261,060	0	315,483	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	103,429	1,745,855	0	2,472,371	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	25,191	783,417	0	1,029,870	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	19,290	1,902,082	0	2,210,341	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	7,726	850,647	0	1,067,430	41.00
43.00	04300	NURSERY	952	0	489,076	0	674,866	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	226,157	2,124,970	0	3,307,069	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	0	529,204	0	775,861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	112,424	946,110	0	1,583,733	54.00
56.00	05600	RADIOISOTOPE	1,138	51,131	267,978	0	1,049,306	56.00
60.00	06000	LABORATORY	3,406	131,731	961,936	0	2,793,057	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	199	0	0	0	5,794	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	73,863	590,505	0	911,945	65.00
66.00	06600	PHYSICAL THERAPY	6,745	91,453	1,107,797	0	1,562,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	19,298	425,059	0	551,591	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	14,035	193,317	0	258,371	68.00
69.00	06900	ELECTROCARDIOLOGY	620	2,734	64,610	0	90,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	531	0	0	2,311,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	558,603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	0	0	0	4,138,847	73.00
76.00	03020	CARDIAC REHAB	2,299	0	118,917	0	183,205	76.00
76.01	03030	ADDICTION SERVICES	0	0	235,638	0	347,166	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	3,550	745,107	0	1,036,905	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	1,013	558,723	0	785,267	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,355	6,946	1,047,579	0	1,512,234	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,942	4,729	1,641,569	0	2,199,835	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	695	550,161	0	747,301	88.05
90.00	09000	CLINIC	3,759	1,801	219,102	0	568,760	90.00
90.01	09001	ONCOLOGY	3,855	0	297,088	0	416,049	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,450	54,412	1,412,831	0	5,192,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,834	94	375,714	0	545,051	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	195,163	2,335,202	0	3,514,510	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	0	239,061	0	464,318	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,385	1,408,261	28,351,767	-8,637,708	53,753,541	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	10,158	68,480	2,893,482	0	5,224,804	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,477,256	1,426,359	6,497,509		8,637,708	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.032435	0.965883	0.207952		0.146456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,613		287,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000212		0.004880	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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	205,669					6.00
7.00	00700	OPERATION OF PLANT	43,386	162,283				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	467	239,335			8.00
9.00	00900	HOUSEKEEPING	1,546	1,546	63,375	160,270		9.00
10.00	01000	DIETARY	4,054	4,054	1,300	4,054	28,917	10.00
11.00	01100	CAFETERIA	1,485	1,485	0	1,485	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	2,983	0	2,983	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	4,485	0	4,485	0	14.00
15.00	01500	PHARMACY	1,815	1,815	0	1,815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	9,898	0	9,898	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	9,473	45,509	9,473	9,893	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	2,391	6,500	2,391	3,370	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	9,842	0	9,842	11,632	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	8,674	7,802	8,674	4,022	41.00
43.00	04300	NURSERY	952	952	0	952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	13,558	20,803	13,558	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	9,856	0	9,856	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	12,166	4,806	12,166	0	54.00
56.00	05600	RADIOISOTOPE	1,138	1,138	0	1,138	0	56.00
60.00	06000	LABORATORY	3,406	3,406	0	3,406	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	199	199	0	199	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	2,617	1,300	2,617	0	65.00
66.00	06600	PHYSICAL THERAPY	6,745	6,745	17,430	6,745	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	1,437	3,713	1,437	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	1,018	2,631	1,018	0	68.00
69.00	06900	ELECTROCARDIOLOGY	620	620	0	620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	321	0	321	0	73.00
76.00	03020	CARDIAC REHAB	2,299	2,299	0	2,299	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	4,865	8,472	4,865	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	3,484	0	3,484	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,355	5,355	0	5,355	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,942	1,942	550	1,942	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	2,551	0	2,551	0	88.05
90.00	09000	CLINIC	3,759	3,759	1,381	3,759	0	90.00
90.01	09001	ONCOLOGY	3,855	3,855	3,901	3,855	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,450	6,450	11,703	6,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,834	5,834	18,204	5,834	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	5,201	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	585	0	585	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	195,511	152,125	224,581	150,112	28,917	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	10,158	10,158	14,754	10,158	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,801,744	2,072,874	161,855	1,149,084	477,055	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	13.622588	12.773205	0.676270	7.169676	16.497389	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,181	503,354	7,434	31,018	69,103	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.423890	3.101705	0.031061	0.193536	2.389702	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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	803,461					11.00
13.00	01300	NURSING ADMINISTRATION	19,070	368,063				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,669	0	4,610,312			14.00
15.00	01500	PHARMACY	14,672	0	4,372	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,556	0	27	0	163,795,258	16.00
17.00	01700	SOCIAL SERVICE	8,730	0	97	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,945	57,945	64,333	0	6,239,243	30.00
31.00	03100	INTENSIVE CARE UNIT	21,489	21,489	11,740	0	1,277,225	31.00
40.00	04000	SUBPROVIDER - IPF	57,571	57,571	15,432	0	6,425,771	40.00
41.00	04100	SUBPROVIDER - IRF	25,809	25,809	7,773	0	2,000,932	41.00
43.00	04300	NURSERY	12,684	12,684	35,754	0	1,164,751	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,257	45,257	109,128	0	13,856,778	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,672	17,672	0	0	1,177,754	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,268	25,268	42,040	0	23,481,565	54.00
56.00	05600	RADIOISOTOPE	5,893	5,893	16,046	0	6,098,034	56.00
60.00	06000	LABORATORY	39,507	39,507	1,263,371	0	19,936,999	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	582,479	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,444	0	55,108	0	4,668,430	65.00
66.00	06600	PHYSICAL THERAPY	33,669	0	2,354	0	6,515,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,161	0	0	0	3,190,992	67.00
68.00	06800	SPEECH PATHOLOGY	4,400	0	8	0	868,070	68.00
69.00	06900	ELECTROCARDIOLOGY	1,727	0	2,822	0	1,041,396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,311,300	0	8,596,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	558,603	0	1,792,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	18,067,724	73.00
76.00	03020	CARDIAC REHAB	3,006	3,006	3,070	0	490,266	76.00
76.01	03030	ADDICTION SERVICES	9,106	9,106	0	0	81,092	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,233	0	2,303	0	1,186,590	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,835	0	2,769	0	504,987	88.01
88.02	08802	RURAL HEALTH CLINIC III	28,906	0	8,940	0	2,457,559	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	23,986	0	6,086	0	2,088,347	88.04
88.05	08804	RURAL HEALTH CLINIC VI	14,006	0	2,473	0	791,460	88.05
90.00	09000	CLINIC	6,629	0	6,746	0	2,142,852	90.00
90.01	09001	ONCOLOGY	9,848	0	5,575	0	1,138,274	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	39,908	39,908	30,112	0	19,247,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	11,636	0	234	0	896,680	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	83,141	0	29,191	0	4,970,621	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,948	6,948	5,307	0	817,520	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	721,381	368,063	4,603,114	100	163,795,258	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	82,080	0	7,198	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	415,250	1,105,327	800,188	1,031,790	1,364,993	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.516827	3.003092	0.173565	10,317.900000	0.008334	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,507	66,032	116,181	45,466	154,567	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.029257	0.179404	0.025200	454.660000	0.000944	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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
17.00	01700	SOCIAL SERVICE	7,661		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	91		30.00
31.00	03100	INTENSIVE CARE UNIT	105		31.00
40.00	04000	SUBPROVIDER - IPF	2,605		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	CARDIAC REHAB	0		76.00
76.01	03030	ADDICTION SERVICES	0		76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		88.03
88.04	08803	RURAL HEALTH CLINIC V	0		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0		88.05
90.00	09000	CLINIC	0		90.00
90.01	09001	ONCOLOGY	0		90.01
90.02	09002	PAIN MANAGEMENT	0		90.02
91.00	09100	EMERGENCY	657		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	4,203		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
99.10	09910	CORF	0		99.10
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,661		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	366,216		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.802637		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 9:20 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	1,852		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.241744		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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,617,894		3,617,894	0	3,617,894	30.00
31.00	03100	INTENSIVE CARE UNIT	1,414,289		1,414,289	0	1,414,289	31.00
40.00	04000	SUBPROVIDER - IPF	3,439,710		3,439,710	0	3,439,710	40.00
41.00	04100	SUBPROVIDER - IRF	1,695,408		1,695,408	0	1,695,408	41.00
43.00	04300	NURSERY	866,218		866,218	0	866,218	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,554,282		4,554,282	0	4,554,282	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,292,330		1,292,330	0	1,292,330	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519,145		2,519,145	0	2,519,145	54.00
56.00	05600	RADIOISOTOPE	1,315,530		1,315,530	0	1,315,530	56.00
60.00	06000	LABORATORY	3,840,935		3,840,935	0	3,840,935	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	18,177		18,177	0	18,177	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,191,195	0	1,191,195	0	1,191,195	65.00
66.00	06600	PHYSICAL THERAPY	2,101,495	0	2,101,495	0	2,101,495	66.00
67.00	06700	OCCUPATIONAL THERAPY	715,999	0	715,999	0	715,999	67.00
68.00	06800	SPEECH PATHOLOGY	341,669	0	341,669	0	341,669	68.00
69.00	06900	ELECTROCARDIOLOGY	135,026		135,026	0	135,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,123,192		3,123,192	0	3,123,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	752,303		752,303	0	752,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,938,146		5,938,146	0	5,938,146	73.00
76.00	03020	CARDIAC REHAB	302,403		302,403	0	302,403	76.00
76.01	03030	ADDICTION SERVICES	430,739		430,739	0	430,739	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,376,470		1,376,470	0	1,376,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,028,539		1,028,539	0	1,028,539	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,950,426		1,950,426	0	1,950,426	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	2,618,428		2,618,428	0	2,618,428	88.04
88.05	08804	RURAL HEALTH CLINIC VI	956,637		956,637	0	956,637	88.05
90.00	09000	CLINIC	801,620		801,620	0	801,620	90.00
90.01	09001	ONCOLOGY	624,559		624,559	0	624,559	90.01
90.02	09002	PAIN MANAGEMENT	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,514,897		6,514,897	0	6,514,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,602,443		1,602,443		1,602,443	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1,047,452		1,047,452	0	1,047,452	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,122,207		4,122,207	0	4,122,207	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	584,145		584,145		584,145	116.00
200.00		Subtotal (see instructions)	62,833,908	0	62,833,908	0	62,833,908	200.00
201.00		Less Observation Beds	1,602,443		1,602,443		1,602,443	201.00
202.00		Total (see instructions)	61,231,465	0	61,231,465	0	61,231,465	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | 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	2,494,487		2,494,487			30.00
31.00	03100	INTENSIVE CARE UNIT	1,277,225		1,277,225			31.00
40.00	04000	SUBPROVIDER - IPF	6,425,771		6,425,771			40.00
41.00	04100	SUBPROVIDER - IRF	2,000,932		2,000,932			41.00
43.00	04300	NURSERY	1,164,751		1,164,751			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,873,664	11,983,114	13,856,778	0.328668	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	868,246	309,508	1,177,754	1.097283	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,412,907	21,068,658	23,481,565	0.107282	0.000000	54.00
56.00	05600	RADIOISOTOPE	480,598	5,617,436	6,098,034	0.215730	0.000000	56.00
60.00	06000	LABORATORY	3,843,442	16,093,557	19,936,999	0.192654	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	337,931	244,548	582,479	0.031206	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,493,071	2,175,359	4,668,430	0.255160	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,070,083	5,445,027	6,515,110	0.322557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	875,548	2,315,444	3,190,992	0.224381	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	236,804	631,266	868,070	0.393596	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	206,483	834,913	1,041,396	0.129659	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,210,548	6,385,793	8,596,341	0.363316	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	273,867	1,518,133	1,792,000	0.419812	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,333,661	14,734,063	18,067,724	0.328660	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	490,266	490,266	0.616814	0.000000	76.00
76.01	03030	ADDICTION SERVICES	1,125	79,967	81,092	5.311732	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,186,590	1,186,590			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	504,987	504,987			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,457,559	2,457,559			88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0			88.03
88.04	08803	RURAL HEALTH CLINIC V	0	2,088,347	2,088,347			88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	791,460	791,460			88.05
90.00	09000	CLINIC	0	2,142,852	2,142,852	0.374090	0.000000	90.00
90.01	09001	ONCOLOGY	250	1,138,024	1,138,274	0.548690	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	1,675,266	17,572,150	19,247,416	0.338482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	368,150	3,376,606	3,744,756	0.427917	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	204	896,476	896,680	1.168145	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,970,621	4,970,621	0.829314	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	817,520	817,520			116.00
200.00		Subtotal (see instructions)	35,925,014	127,870,244	163,795,258			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	35,925,014	127,870,244	163,795,258			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.328668	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	54.00
56.00	05600	RADIOISOTOPE	0.215730	56.00
60.00	06000	LABORATORY	0.192654	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	73.00
76.00	03020	CARDIAC REHAB	0.616814	76.00
76.01	03030	ADDICTION SERVICES	5.311732	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08805	RURAL HEALTH CLINIC IV		88.03
88.04	08803	RURAL HEALTH CLINIC V		88.04
88.05	08804	RURAL HEALTH CLINIC VI		88.05
90.00	09000	CLINIC	0.374090	90.00
90.01	09001	ONCOLOGY	0.548690	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	90.02
91.00	09100	EMERGENCY	0.338482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.829314	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,617,894		3,617,894	0	3,617,894	30.00
31.00	03100	INTENSIVE CARE UNIT	1,414,289		1,414,289	0	1,414,289	31.00
40.00	04000	SUBPROVIDER - IPF	3,439,710		3,439,710	0	3,439,710	40.00
41.00	04100	SUBPROVIDER - IRF	1,695,408		1,695,408	0	1,695,408	41.00
43.00	04300	NURSERY	866,218		866,218	0	866,218	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,554,282		4,554,282	0	4,554,282	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,292,330		1,292,330	0	1,292,330	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519,145		2,519,145	0	2,519,145	54.00
56.00	05600	RADIOISOTOPE	1,315,530		1,315,530	0	1,315,530	56.00
60.00	06000	LABORATORY	3,840,935		3,840,935	0	3,840,935	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	18,177		18,177	0	18,177	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,191,195	0	1,191,195	0	1,191,195	65.00
66.00	06600	PHYSICAL THERAPY	2,101,495	0	2,101,495	0	2,101,495	66.00
67.00	06700	OCCUPATIONAL THERAPY	715,999	0	715,999	0	715,999	67.00
68.00	06800	SPEECH PATHOLOGY	341,669	0	341,669	0	341,669	68.00
69.00	06900	ELECTROCARDIOLOGY	135,026		135,026	0	135,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,123,192		3,123,192	0	3,123,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	752,303		752,303	0	752,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,938,146		5,938,146	0	5,938,146	73.00
76.00	03020	CARDIAC REHAB	302,403		302,403	0	302,403	76.00
76.01	03030	ADDICTION SERVICES	430,739		430,739	0	430,739	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,376,470		1,376,470	0	1,376,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,028,539		1,028,539	0	1,028,539	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,950,426		1,950,426	0	1,950,426	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	2,618,428		2,618,428	0	2,618,428	88.04
88.05	08804	RURAL HEALTH CLINIC VI	956,637		956,637	0	956,637	88.05
90.00	09000	CLINIC	801,620		801,620	0	801,620	90.00
90.01	09001	ONCOLOGY	624,559		624,559	0	624,559	90.01
90.02	09002	PAIN MANAGEMENT	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,514,897		6,514,897	0	6,514,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,602,443		1,602,443		1,602,443	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1,047,452		1,047,452	0	1,047,452	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,122,207		4,122,207	0	4,122,207	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	584,145		584,145		584,145	116.00
200.00		Subtotal (see instructions)	62,833,908	0	62,833,908	0	62,833,908	200.00
201.00		Less Observation Beds	1,602,443		1,602,443		1,602,443	201.00
202.00		Total (see instructions)	61,231,465	0	61,231,465	0	61,231,465	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,494,487		2,494,487			30.00
31.00	03100	INTENSIVE CARE UNIT	1,277,225		1,277,225			31.00
40.00	04000	SUBPROVIDER - IPF	6,425,771		6,425,771			40.00
41.00	04100	SUBPROVIDER - IRF	2,000,932		2,000,932			41.00
43.00	04300	NURSERY	1,164,751		1,164,751			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,873,664	11,983,114	13,856,778	0.328668	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	868,246	309,508	1,177,754	1.097283	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,412,907	21,068,658	23,481,565	0.107282	0.000000	54.00
56.00	05600	RADIOISOTOPE	480,598	5,617,436	6,098,034	0.215730	0.000000	56.00
60.00	06000	LABORATORY	3,843,442	16,093,557	19,936,999	0.192654	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	337,931	244,548	582,479	0.031206	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,493,071	2,175,359	4,668,430	0.255160	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,070,083	5,445,027	6,515,110	0.322557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	875,548	2,315,444	3,190,992	0.224381	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	236,804	631,266	868,070	0.393596	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	206,483	834,913	1,041,396	0.129659	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,210,548	6,385,793	8,596,341	0.363316	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	273,867	1,518,133	1,792,000	0.419812	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,333,661	14,734,063	18,067,724	0.328660	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	490,266	490,266	0.616814	0.000000	76.00
76.01	03030	ADDICTION SERVICES	1,125	79,967	81,092	5.311732	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,186,590	1,186,590	1.160022	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	504,987	504,987	2.036763	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,457,559	2,457,559	0.793644	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0.000000	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	2,088,347	2,088,347	1.253828	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	791,460	791,460	1.208699	0.000000	88.05
90.00	09000	CLINIC	0	2,142,852	2,142,852	0.374090	0.000000	90.00
90.01	09001	ONCOLOGY	250	1,138,024	1,138,274	0.548690	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	1,675,266	17,572,150	19,247,416	0.338482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	368,150	3,376,606	3,744,756	0.427917	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	204	896,476	896,680	1.168145	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,970,621	4,970,621	0.829314	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	817,520	817,520			116.00
200.00		Subtotal (see instructions)	35,925,014	127,870,244	163,795,258			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	35,925,014	127,870,244	163,795,258			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	CARDIAC REHAB	0.000000		76.00
76.01	03030	ADDICTION SERVICES	0.000000		76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY	0.000000		90.01
90.02	09002	PAIN MANAGEMENT	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	296,756	0	296,756	3,355	88.45	30.00
31.00	INTENSIVE CARE UNIT	79,062		79,062	574	137.74	31.00
40.00	SUBPROVIDER - IPF	221,901	0	221,901	3,864	57.43	40.00
41.00	SUBPROVIDER - IRF	158,129	0	158,129	1,344	117.66	41.00
43.00	NURSERY	22,089		22,089	886	24.93	43.00
200.00	Total (lines 30 through 199)	777,937		777,937	10,023		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	590	52,186				30.00
31.00	INTENSIVE CARE UNIT	238	32,782				31.00
40.00	SUBPROVIDER - IPF	3,064	175,966				40.00
41.00	SUBPROVIDER - IRF	1,119	131,662				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	5,011	392,596				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	460,952	13,856,778	0.033265	576,982	19,193	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,088	1,177,754	0.130832	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,574	23,481,565	0.013823	995,103	13,755	54.00
56.00	05600	RADIOISOTOPE	78,742	6,098,034	0.012913	192,896	2,491	56.00
60.00	06000	LABORATORY	250,216	19,936,999	0.012550	1,233,995	15,487	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,513	582,479	0.006031	98,070	591	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	120,839	4,668,430	0.025884	489,348	12,666	65.00
66.00	06600	PHYSICAL THERAPY	203,426	6,515,110	0.031224	111,819	3,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,103	3,190,992	0.014448	46,652	674	67.00
68.00	06800	SPEECH PATHOLOGY	30,906	868,070	0.035603	27,303	972	68.00
69.00	06900	ELECTROCARDIOLOGY	13,349	1,041,396	0.012818	81,645	1,047	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,158	8,596,341	0.009092	519,914	4,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,495	1,792,000	0.010321	160,182	1,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,455	18,067,724	0.004840	601,007	2,909	73.00
76.00	03020	CARDIAC REHAB	36,001	490,266	0.073432	0	0	76.00
76.01	03030	ADDICTION SERVICES	3,721	81,092	0.045886	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,330	1,186,590	0.069384	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,245	504,987	0.113359	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	96,697	2,457,559	0.039347	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	47,142	2,088,347	0.022574	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	43,285	791,460	0.054690	0	0	88.05
90.00	09000	CLINIC	62,443	2,142,852	0.029140	0	0	90.00
90.01	09001	ONCOLOGY	60,584	1,138,274	0.053224	210	11	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	201,122	19,247,416	0.010449	675,913	7,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	131,440	3,744,756	0.035100	168,552	5,916	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	91,664	896,680	0.102226	105	11	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,784,490	144,643,951		5,979,696	92,657	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	3,355	0.00	590	30.00
31.00	03100	INTENSIVE CARE UNIT		0	574	0.00	238	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,864	0.00	3,064	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,344	0.00	1,119	41.00
43.00	04300	NURSERY		0	886	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	10,023		5,011	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,856,778	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,177,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,481,565	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	6,098,034	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	19,936,999	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	582,479	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,668,430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,515,110	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,190,992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	868,070	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,041,396	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,596,341	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,792,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,067,724	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	490,266	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	81,092	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,186,590	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	504,987	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,457,559	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	2,088,347	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	791,460	0.000000	88.05
90.00	09000	CLINIC	0	0	0	2,142,852	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,138,274	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,247,416	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,744,756	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	896,680	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	144,643,951		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	576,982	0	1,776,377	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	81,433	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	995,103	0	4,512,107	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	192,896	0	1,655,826	0	56.00
60.00	06000	LABORATORY	0.000000	1,233,995	0	1,767,498	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	98,070	0	63,750	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	489,348	0	345,374	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	111,819	0	8,538	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,652	0	126	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	27,303	0	5,917	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	81,645	0	210,962	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	519,914	0	1,240,354	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	160,182	0	472,041	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	601,007	0	6,754,763	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	237,183	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	1,105,181	0	90.00
90.01	09001	ONCOLOGY	0.000000	210	0	602,719	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	675,913	0	2,855,038	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	168,552	0	1,142,112	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	105	0	98,968	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,979,696	0	24,936,267	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.328668	1,776,377	0	0	583,838	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	81,433	0	0	89,355	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	4,512,107	0	0	484,068	54.00
56.00	05600	RADIOISOTOPE	0.215730	1,655,826	0	0	357,211	56.00
60.00	06000	LABORATORY	0.192654	1,767,498	0	0	340,516	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	63,750	0	0	1,989	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	345,374	0	0	88,126	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	8,538	0	0	2,754	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	126	0	0	28	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	5,917	0	0	2,329	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	210,962	0	0	27,353	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	1,240,354	0	0	450,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	472,041	0	0	198,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	6,754,763	0	4,797	2,220,020	73.00
76.00	03020	CARDIAC REHAB	0.616814	237,183	0	0	146,298	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08805	RURAL HEALTH CLINIC IV						88.03
88.04	08803	RURAL HEALTH CLINIC V						88.04
88.05	08804	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.374090	1,105,181	0	0	413,437	90.00
90.01	09001	ONCOLOGY	0.548690	602,719	0	0	330,706	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.338482	2,855,038	0	252	966,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	1,142,112	0	0	488,729	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	98,968	0	0	115,609	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.829314		0			95.00
200.00		Subtotal (see instructions)		24,936,267	0	5,049	7,307,553	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		24,936,267	0	5,049	7,307,553	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,577		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.01	03030	ADDICTION SERVICES	0	0		76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08805	RURAL HEALTH CLINIC IV				88.03
88.04	08803	RURAL HEALTH CLINIC V				88.04
88.05	08804	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ONCOLOGY	0	0		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	0	85		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,662		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,662		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | 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	460,952	13,856,778	0.033265	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,088	1,177,754	0.130832	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,574	23,481,565	0.013823	230,146	3,181	54.00
56.00	05600	RADIOISOTOPE	78,742	6,098,034	0.012913	21,121	273	56.00
60.00	06000	LABORATORY	250,216	19,936,999	0.012550	604,824	7,591	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,513	582,479	0.006031	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	120,839	4,668,430	0.025884	396,968	10,275	65.00
66.00	06600	PHYSICAL THERAPY	203,426	6,515,110	0.031224	80,078	2,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,103	3,190,992	0.014448	7,179	104	67.00
68.00	06800	SPEECH PATHOLOGY	30,906	868,070	0.035603	37,334	1,329	68.00
69.00	06900	ELECTROCARDIOLOGY	13,349	1,041,396	0.012818	38,826	498	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,158	8,596,341	0.009092	71,006	646	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,495	1,792,000	0.010321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,455	18,067,724	0.004840	1,146,251	5,548	73.00
76.00	03020	CARDIAC REHAB	36,001	490,266	0.073432	0	0	76.00
76.01	03030	ADDICTION SERVICES	3,721	81,092	0.045886	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,330	1,186,590	0.069384	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,245	504,987	0.113359	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	96,697	2,457,559	0.039347	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	47,142	2,088,347	0.022574	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	43,285	791,460	0.054690	0	0	88.05
90.00	09000	CLINIC	62,443	2,142,852	0.029140	0	0	90.00
90.01	09001	ONCOLOGY	60,584	1,138,274	0.053224	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	201,122	19,247,416	0.010449	236,044	2,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,744,756	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	91,664	896,680	0.102226	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,653,050	144,643,951		2,869,777	34,411	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | 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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | 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	13,856,778	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,177,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,481,565	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	6,098,034	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	19,936,999	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	582,479	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,668,430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,515,110	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,190,992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	868,070	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,041,396	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,596,341	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,792,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,067,724	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	490,266	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	81,092	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,186,590	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	504,987	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,457,559	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	2,088,347	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	791,460	0.000000	88.05
90.00	09000	CLINIC	0	0	0	2,142,852	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,138,274	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,247,416	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,744,756	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	896,680	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	144,643,951		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	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	230,146	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	21,121	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	604,824	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	396,968	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	80,078	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	7,179	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	37,334	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	38,826	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71,006	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	1,146,251	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	236,044	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,869,777	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | 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	460,952	13,856,778	0.033265	412	14	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,088	1,177,754	0.130832	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,574	23,481,565	0.013823	83,861	1,159	54.00
56.00	05600	RADIOISOTOPE	78,742	6,098,034	0.012913	8,478	109	56.00
60.00	06000	LABORATORY	250,216	19,936,999	0.012550	151,831	1,905	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,513	582,479	0.006031	14,506	87	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	120,839	4,668,430	0.025884	577,648	14,952	65.00
66.00	06600	PHYSICAL THERAPY	203,426	6,515,110	0.031224	634,224	19,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,103	3,190,992	0.014448	539,008	7,788	67.00
68.00	06800	SPEECH PATHOLOGY	30,906	868,070	0.035603	116,842	4,160	68.00
69.00	06900	ELECTROCARDIOLOGY	13,349	1,041,396	0.012818	7,205	92	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,158	8,596,341	0.009092	118,319	1,076	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,495	1,792,000	0.010321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,455	18,067,724	0.004840	227,876	1,103	73.00
76.00	03020	CARDIAC REHAB	36,001	490,266	0.073432	0	0	76.00
76.01	03030	ADDICTION SERVICES	3,721	81,092	0.045886	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,330	1,186,590	0.069384	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,245	504,987	0.113359	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	96,697	2,457,559	0.039347	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	47,142	2,088,347	0.022574	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	43,285	791,460	0.054690	0	0	88.05
90.00	09000	CLINIC	62,443	2,142,852	0.029140	0	0	90.00
90.01	09001	ONCOLOGY	60,584	1,138,274	0.053224	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	201,122	19,247,416	0.010449	57,140	597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,744,756	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	91,664	896,680	0.102226	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,653,050	144,643,951		2,537,350	52,845	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | 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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | 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	13,856,778	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,177,754	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,481,565	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	6,098,034	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	19,936,999	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	582,479	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,668,430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,515,110	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,190,992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	868,070	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,041,396	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,596,341	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,792,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,067,724	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	490,266	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	81,092	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,186,590	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	504,987	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,457,559	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	2,088,347	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	791,460	0.000000	88.05
90.00	09000	CLINIC	0	0	0	2,142,852	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,138,274	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,247,416	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,744,756	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	896,680	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	144,643,951		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | 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	412	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	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	83,861	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	8,478	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	151,831	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	14,506	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	577,648	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	634,224	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	539,008	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	116,842	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,205	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	118,319	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	227,876	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	57,140	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,537,350	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | 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	0.328668	0	282,854	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	7,306	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	0	497,313	0	0	54.00
56.00	05600	RADIOISOTOPE	0.215730	0	132,596	0	0	56.00
60.00	06000	LABORATORY	0.192654	0	379,879	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	0	5,772	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	0	51,348	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	0	128,527	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	0	54,655	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	0	14,901	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	0	19,708	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	0	150,733	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	0	35,835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	0	347,789	0	0	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	11,572	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	1,888	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08805	RURAL HEALTH CLINIC IV						88.03
88.04	08803	RURAL HEALTH CLINIC V						88.04
88.05	08804	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.374090	0	50,581	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	0	26,863	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.338482	0	414,780	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	0	79,703	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	0	21,161	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.829314	0	0			95.00
200.00		Subtotal (see instructions)		0	2,715,764	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,715,764	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | 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	92,965	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,017	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,353	0		54.00
56.00	05600	RADIOISOTOPE	28,605	0		56.00
60.00	06000	LABORATORY	73,185	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	180	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	13,102	0		65.00
66.00	06600	PHYSICAL THERAPY	41,457	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,264	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,865	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,555	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,764	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,044	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,304	0		73.00
76.00	03020	CARDIAC REHAB	7,138	0		76.00
76.01	03030	ADDICTION SERVICES	10,029	0		76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08805	RURAL HEALTH CLINIC IV				88.03
88.04	08803	RURAL HEALTH CLINIC V				88.04
88.05	08804	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	18,922	0		90.00
90.01	09001	ONCOLOGY	14,739	0		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	140,396	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,106	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	24,719	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	765,709	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	765,709	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,355	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,869	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	590	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,617,894	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,617,894	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)	3,617,894	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,078.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	636,232	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)	636,232	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,414,289	574	2,463.92	238	586,413	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)	1,526,344	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)	2,748,989	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)	84,968	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	92,657	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	177,625	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,571,364	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)	1,486	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.36	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,602,443	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	296,756	3,617,894	0.082025	1,602,443	131,440	90.00
91.00	Nursing Program cost	0	3,617,894	0.000000	1,602,443	0	91.00
92.00	Allied health cost	0	3,617,894	0.000000	1,602,443	0	92.00
93.00	All other Medical Education	0	3,617,894	0.000000	1,602,443	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IPF	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)	3,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,864	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)	3,864	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,064	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,439,710	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,439,710	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)	3,439,710	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)	890.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,727,542	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)	2,727,542	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	776,651	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)	3,504,193	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)	175,966	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	34,411	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	210,377	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,293,816	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IPF	PPS

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	221,901	3,439,710	0.064512	0	0	90.00
91.00	Nursing Program cost	0	3,439,710	0.000000	0	0	91.00
92.00	Allied health cost	0	3,439,710	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,439,710	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IRF	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)	1,344	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,344	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,344	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,119	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,695,408	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,695,408	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)	1,695,408	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,261.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,411,574	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,411,574	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	697,719	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,109,293	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)	131,662	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	52,845	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	184,507	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,924,786	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IRF	PPS

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	158,129	1,695,408	0.093269	0	0	90.00
91.00	Nursing Program cost	0	1,695,408	0.000000	0	0	91.00
92.00	Allied health cost	0	1,695,408	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,695,408	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | 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)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,355	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,869	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	89	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)	886	15.00
16.00	Nursery days (title V or XIX only)	78	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,617,894	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,617,894	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)	3,617,894	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,078.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	95,974	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)	95,974	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | 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)	866,218	886	977.67	78	76,258	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,414,289	574	2,463.92	24	59,134	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)	288,737	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)	520,103	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)	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)	1,486	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.36	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,602,443	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	296,756	3,617,894	0.082025	1,602,443	131,440	90.00
91.00	Nursing Program cost	0	3,617,894	0.000000	1,602,443	0	91.00
92.00	Allied health cost	0	3,617,894	0.000000	1,602,443	0	92.00
93.00	All other Medical Education	0	3,617,894	0.000000	1,602,443	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XIX	Subprovider - IPF	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)	3,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,864	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)	3,864	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	886	15.00
16.00	Nursery days (title V or XIX only)	78	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,439,710	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,439,710	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)	3,439,710	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)	890.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Subprovider - IPF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	32,873	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)	32,873	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)	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description					1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	221,901	3,439,710	0.064512	0	0	90.00
91.00	Nursing Program cost	0	3,439,710	0.000000	0	0	91.00
92.00	Allied health cost	0	3,439,710	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,439,710	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,344	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,344	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,344	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	886	15.00
16.00	Nursery days (title V or XIX only)	78	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,695,408	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,695,408	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)	1,695,408	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,261.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	0	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)	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 9:20 am
	Title XIX	Subprovider - IRF	Cost

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	158,129	1,695,408	0.093269	0	0	90.00
91.00	Nursing Program cost	0	1,695,408	0.000000	0	0	91.00
92.00	Allied health cost	0	1,695,408	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,695,408	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		509,592		30.00
31.00	03100	INTENSIVE CARE UNIT		629,488		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	576,982	189,636	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	995,103	106,757	54.00
56.00	05600	RADIOISOTOPE	0.215730	192,896	41,613	56.00
60.00	06000	LABORATORY	0.192654	1,233,995	237,734	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	98,070	3,060	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	489,348	124,862	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	111,819	36,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	46,652	10,468	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	27,303	10,746	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	81,645	10,586	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	519,914	188,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	160,182	67,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	601,007	197,527	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	210	115	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	675,913	228,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	168,552	72,126	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	105	123	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,979,696	1,526,344	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)		5,979,696		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-S061 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		5,124,957		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	230,146	24,691	54.00
56.00	05600	RADIOISOTOPE	0.215730	21,121	4,556	56.00
60.00	06000	LABORATORY	0.192654	604,824	116,522	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	396,968	101,290	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	80,078	25,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	7,179	1,611	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	37,334	14,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	38,826	5,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	71,006	25,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	1,146,251	376,727	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	236,044	79,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,869,777	776,651	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,869,777		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		1,672,346		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	412	135	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	83,861	8,997	54.00
56.00	05600	RADIOISOTOPE	0.215730	8,478	1,829	56.00
60.00	06000	LABORATORY	0.192654	151,831	29,251	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	14,506	453	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	577,648	147,393	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	634,224	204,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	539,008	120,943	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	116,842	45,989	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	7,205	934	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	118,319	42,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	227,876	74,894	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	57,140	19,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,537,350	697,719	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,537,350		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | 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		107,109		30.00
31.00	03100	INTENSIVE CARE UNIT		54,842		31.00
40.00	04000	SUBPROVIDER - IPF		275,911		40.00
41.00	04100	SUBPROVIDER - IRF		85,916		41.00
43.00	04300	NURSERY		50,012		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	80,452	26,442	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	37,281	40,908	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	103,606	11,115	54.00
56.00	05600	RADIOISOTOPE	0.215730	20,636	4,452	56.00
60.00	06000	LABORATORY	0.192654	165,030	31,794	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	14,510	453	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	107,048	27,314	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	45,947	14,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	37,594	8,435	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	10,168	4,002	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	8,866	1,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	94,917	34,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	11,759	4,937	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	143,141	47,045	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	48	255	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.160022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.036763	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.793644	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1.253828	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.208699	0	0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	9	5	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	71,933	24,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	15,808	6,765	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	9	11	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		968,762	288,737	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)		968,762		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		246,401		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	8,097	869	54.00
56.00	05600	RADIOISOTOPE	0.215730	848	183	56.00
60.00	06000	LABORATORY	0.192654	23,620	4,550	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	2	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	18,135	4,627	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	3,408	1,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	295	66	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	1,404	553	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	1,620	210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	863	314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	48,176	15,834	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.160022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.036763	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.793644	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1.253828	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.208699	0	0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	13,337	4,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	46	54	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		119,851	32,873	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)		119,851		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		1		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328668	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097283	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107282	0	0	54.00
56.00	05600	RADIOISOTOPE	0.215730	0	0	56.00
60.00	06000	LABORATORY	0.192654	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.031206	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.255160	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322557	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.224381	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.393596	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129659	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.363316	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419812	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328660	0	0	73.00
76.00	03020	CARDIAC REHAB	0.616814	0	0	76.00
76.01	03030	ADDICTION SERVICES	5.311732	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.160022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.036763	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.793644	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1.253828	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.208699	0	0	88.05
90.00	09000	CLINIC	0.374090	0	0	90.00
90.01	09001	ONCOLOGY	0.548690	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.338482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.427917	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.168145	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,582,947	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	545,309	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	886,868	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	37.86	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.65	30.00
31.00	Percentage of Medicaid patient days (see instructions)	34.12	31.00
32.00	Sum of lines 30 and 31	38.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		63,848	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000066664	0.000063990	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	458,274	379,974	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	342,764	95,513	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	438,277		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,630,381		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	2,630,381	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	159,145	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	2,789,526	59.00
60.00	Primary payer payments	4,383	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,785,143	61.00
62.00	Deductibles billed to program beneficiaries	327,780	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	28,683	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	18,644	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,125	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,476,007	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-9,699	70.93
70.94	HRR adjustment amount (see instructions)	-633	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	400,489	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2024	142,116	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,008,280	71.00
71.01	Sequestration adjustment (see instructions)		60,166	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		2,694,907	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		253,207	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,582,947	0	1,582,947		1,582,947	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	545,309	0		545,309	545,309	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	886,868	0	676,530	210,338	886,868	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	63,848	0	47,489	16,359	63,848	11.00
11.01	Uncompensated care payments	36.00	438,277	0	342,764	95,513	438,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,630,381	0	1,973,200	657,181	2,630,381	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,630,381	0	1,973,200	657,181	2,630,381	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	159,145	0	117,134	42,011	159,145	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,090,334	699,192	2,789,526	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	159,145	0	117,134	42,011	159,145	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	159,145	0	117,134	42,011	159,145	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.191591	0.203258		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			400,489		400,489	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				142,116	142,116	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,582,947	1,582,947		1,582,947	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	545,309		545,309	545,309	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	886,868	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	63,848	47,489	16,359	63,848	11.00
11.01	Uncompensated care payments	36.00	438,277	342,764	95,513	438,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,630,381	1,973,200	657,181	2,630,381	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,630,381	1,973,200	657,181	2,630,381	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	159,145	117,134	42,011	159,145	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,090,334	699,192	2,789,526	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	159,145	117,134	42,011	159,145	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	159,145	117,134	42,011	159,145	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	400,489	400,489		400,489	28.00
29.00	Low volume adjustment on or after October 1	70.97	142,116		142,116	142,116	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-9,699	0	-9,699	-9,699	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-633	-633	0	-633	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,662	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,307,553	2.00
3.00	OPPS or REH payments	5,891,817	3.00
4.00	Outlier payment (see instructions)	4,547	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,662	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,049	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)	5,049	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)	5,049	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,387	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)	1,662	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	5,896,364	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,098,344	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,799,682	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,799,682	30.00
31.00	Primary payer payments	948	31.00
32.00	Subtotal (line 30 minus line 31)	4,798,734	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)	102,443	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,588	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	75,875	36.00
37.00	Subtotal (see instructions)	4,865,322	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,865,322	40.00
40.01	Sequestration adjustment (see instructions)	97,306	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,766,884	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	1,132	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,694,907		4,766,884	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)		2,694,907		4,766,884	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		253,207		1,132	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,948,114		4,768,016	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,014,836		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)		3,014,836		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		6,004		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,020,840		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,158,706		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)		2,158,706		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		34,728		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,193,434		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	3,372,616	1.00
2.00	Net IPF PPS Outlier Payments	5,231	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.586301	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3,377,847	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	3,377,847	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	3,377,847	18.00
19.00	Deductibles	143,692	19.00
20.00	Subtotal (line 18 minus line 19)	3,234,155	20.00
21.00	Coinsurance	157,791	21.00
22.00	Subtotal (line 20 minus line 21)	3,076,364	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,424	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	6,126	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,756	25.00
26.00	Subtotal (sum of lines 22 and 24)	3,082,490	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	3,082,490	31.00
31.01	Sequestration adjustment (see instructions)	61,650	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	3,014,836	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	6,004	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	5,231	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,134,283	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0417	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	74,486	3.00
4.00	Outlier Payments	62,657	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.682192	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,271,426	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,271,426	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,271,426	19.00
20.00	Deductibles	35,112	20.00
21.00	Subtotal (line 19 minus line 20)	2,236,314	21.00
22.00	Coinsurance	2,800	22.00
23.00	Subtotal (line 21 minus line 22)	2,233,514	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,206	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	4,684	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,612	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,238,198	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,238,198	32.00
32.01	Sequestration adjustment (see instructions)	44,764	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,158,706	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	34,728	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	62,657	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 5/31/2024 9:20 am

Title XIX | Hospital | Cost

		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	520,103		1.00
2.00	Medical and other services		765,709	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	520,103	765,709	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)	520,103	765,709	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	968,762	2,715,764	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)	968,762	2,715,764	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)	968,762	2,715,764	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	448,659	1,950,055	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)	520,103	765,709	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	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)	0	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)	520,103	765,709	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)	520,103	765,709	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	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)	520,103	765,709	36.00
37.00	ZERO OUT MEDICAID	-520,103	-765,709	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 9:20 am
	Title XIX	Subprovider - IPF	Cost

		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	32,873		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)	32,873	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)	32,873	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	119,851	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)	119,851	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)	119,851	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	86,978	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)	32,873	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	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)	0	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)	32,873	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)	32,873	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	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)	32,873	0	36.00
37.00	ZERO OUT MEDICAID	-32,873	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 9:20 am
	Title XIX	Subprovider - IRF	Cost

		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	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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	0	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)	0	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)	0	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)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 9:20 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	12,713,735	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	25,062,651	0	0	0	4.00
5.00	Other receivable	859,873	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,329,549	0	0	0	6.00
7.00	Inventory	2,396,947	0	0	0	7.00
8.00	Prepaid expenses	551,107	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)	26,254,764	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,280,955	0	0	0	12.00
13.00	Land improvements	687,865	0	0	0	13.00
14.00	Accumulated depreciation	-686,823	0	0	0	14.00
15.00	Buildings	69,258,443	0	0	0	15.00
16.00	Accumulated depreciation	-48,564,532	0	0	0	16.00
17.00	Leasehold improvements	39,119	0	0	0	17.00
18.00	Accumulated depreciation	-37,518	0	0	0	18.00
19.00	Fixed equipment	11,443,481	0	0	0	19.00
20.00	Accumulated depreciation	-8,087,211	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	32,522,742	0	0	0	23.00
24.00	Accumulated depreciation	-27,953,484	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,903,037	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,392,801	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,640,621	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,033,422	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,191,223	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,094,798	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,006,664	0	0	0	38.00
39.00	Payroll taxes payable	689,197	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,490,695	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,325,622	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,606,976	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	6,845,808	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,845,808	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,452,784	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	45,738,443				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)	45,738,443	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,191,227	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 9:20 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		49,797,814		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,359,238				2.00
3.00	Total (sum of line 1 and line 2)		46,438,576		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,438,576		0		11.00
12.00	IDENTIFIED ON TRIAL BALANCE	700,133		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)		700,133		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,738,443		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	IDENTIFIED ON TRIAL BALANCE		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: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2024 9:20 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,837,860		6,837,860	1.00
2.00	SUBPROVIDER - IPF	7,464,147		7,464,147	2.00
3.00	SUBPROVIDER - IRF	2,169,159		2,169,159	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)	16,471,166		16,471,166	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,112,488		2,112,488	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,112,488		2,112,488	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,583,654		18,583,654	17.00
18.00	Ancillary services	23,387,172	123,325,344	146,712,516	18.00
19.00	Outpatient services	0	2,349,671	2,349,671	19.00
20.00	RURAL HEALTH CLINIC	0	1,186,590	1,186,590	20.00
20.01	RURAL HEALTH CLINIC II	0	504,987	504,987	20.01
20.02	RURAL HEALTH CLINIC III	0	2,457,559	2,457,559	20.02
20.03	RURAL HEALTH CLINIC IV	0	0	0	20.03
20.04	RURAL HEALTH CLINIC V	0	2,518,744	2,518,744	20.04
20.05	RURAL HEALTH CLINIC VI	0	791,460	791,460	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	817,520	817,520	26.00
27.00	AMBULANCE	525	4,970,621	4,971,146	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	41,971,351	138,922,496	180,893,847	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,718,475		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	IGT EXPENSES NOT ON W/S A	7,143,886			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)		7,143,886		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		71,574,589		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/31/2024 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	180,893,847	1.00
2.00	Less contractual allowances and discounts on patients' accounts	121,338,229	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,555,618	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	71,574,589	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,018,971	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	728,775	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	4,736	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	162,974	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	142,381	17.00
18.00	Revenue from sale of medical records and abstracts	5,880	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	193,406	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - INCLUDES EHR REVENUE	7,421,581	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,659,733	25.00
26.00	Total (line 5 plus line 25)	-3,359,238	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,359,238	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	85,071	13,879	98,950	0	98,950	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	4,479	4,479	0	4,479	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	64	64	0	64	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	22,242	22,242	0	22,242	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	101,548	128,426	229,974	0	229,974	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	52,442	0	52,442	0	52,442	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	239,061	169,090	408,151	0	408,151	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	98,950		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	4,479		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	64		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	22,242		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	229,974		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	52,442		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	408,151		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0061 Hospice CCN: 15-1553

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

Worksheet O-2 Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	22,100	22,100	0	22,100	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	100,898	127,604	228,502	0	228,502	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	52,106	0	52,106	0	52,106	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	153,004	149,704	302,708	0	302,708	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	22,100		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	228,502		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	52,106		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	302,708		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0061 Hospice CCN: 15-1553 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-4 | Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	142	142	0	142	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	650	822	1,472	0	1,472	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	336	0	336	0	336	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	986	964	1,950	0	1,950	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	142		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,472		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	336		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,950		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0061 Hospice CCN: 15-1553

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

Worksheet O-5

Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	6,454	6,454	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	49,713	49,713	3.00
4.00	ADMINISTRATIVE & GENERAL	98,950	71,593	170,543	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	15,441	15,441	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	4,194	4,194	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	20,865	20,865	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	921	921	10.00
11.00	MEDICAL RECORDS	0	6,813	6,813	11.00
12.00	STAFF TRANSPORTATION	4,479		4,479	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	64	0	64	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	302,708		302,708	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,950		1,950	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	408,151	175,994	584,145	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,454	6,454				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	49,713	0	0	49,713		3.00
4.00	ADMINISTRATIVE & GENERAL	170,543	0	0	18,397	188,940	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,441	0	0	0	15,441	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	4,194	0	0	0	4,194	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	20,865	0	0	0	20,865	9.00
10.00	ROUTINE MEDICAL SUPPLIES	921	0	0	0	921	10.00
11.00	MEDICAL RECORDS	6,813	0	0	0	6,813	11.00
12.00	STAFF TRANSPORTATION	4,479	0	0	0	4,479	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	64	0	0	0	64	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	302,708			31,198	333,906	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,950	0	0	118	2,068	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	6,454	0	0	6,454	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	584,145	6,454	0	49,713	584,145	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	188,940					4.00
5.00	PLANT OPERATION & MAINTENANCE	7,382	22,823				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	2,005	0		6,199		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	9,975	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	440	0		0		10.00
11.00	MEDICAL RECORDS	3,257	0		0		11.00
12.00	STAFF TRANSPORTATION	2,141	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	31	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	159,634					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	989	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3,086	22,823	0	6,199	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	188,940	22,823	0	6,199	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	30,840					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,361				10.00
11.00	MEDICAL RECORDS	0		10,070			11.00
12.00	STAFF TRANSPORTATION	0			6,620		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	30,840	1,351	9,996	6,620	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	10	74	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	30,840	1,361	10,070	6,620	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	95					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	95	0	0		542,442	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	3,141	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	38,562	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	95	0	0	0	584,145	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2024 9:20 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	585					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	236,949			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	87,687	-188,940	395,205	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	15,441	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	4,194	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	20,865	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	921	10.00
11.00	MEDICAL RECORDS	0	0	0	0	6,813	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	4,479	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	64	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			148,700	0	333,906	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	562	0	2,068	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	0	0	6,454	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	6,454	0	49,713		188,940	100.00
101.00	UNIT COST MULTIPLIER	11.032479	0.000000	0.209805		0.478081	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2024 9:20 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	585					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		585			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		7,728	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					7,728	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	585	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	22,823	0	6,199	0	30,840	100.00
101.00	UNIT COST MULTIPLIER	39.013675	0.000000	10.596581	0.000000	3.990683	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2024 9:20 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,993					10.00
11.00	MEDICAL RECORDS		2,993				11.00
12.00	STAFF TRANSPORTATION			4,267			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,971	2,971	4,267	0	270	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	22	22	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	1,361	10,070	6,620	0	95	100.00
101.00	UNIT COST MULTIPLIER	0.454728	3.364517	1.551441	0.000000	0.351852	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0061
Hospice CCN: 15-1553

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2024 9:20 am

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			13		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	13		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0061 Hospice CCN: 15-1553

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

Worksheet O-7

Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.322557	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.224381	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.393596	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.328660	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.192654	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.363316	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	1.168145	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	0.616814	0	0	0	10.00
10.01	ADDICTION SERVICES	76.01	5.311732	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC REHAB	0	0	0	0	0	10.00
10.01	ADDICTION SERVICES	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-8 | Date/Time Prepared: 5/31/2024 9:20 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			542,442	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,971	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			182.58	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,971	0		9.00
10.00	Program cost (line 8 times line 9)	542,445	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			3,141	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			22	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			142.77	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	22	0		19.00
20.00	Program cost (line 18 times line 19)	3,141	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			545,583	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,993	22.00
23.00	Average cost per diem (line 21 divided by line 22)			182.29	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	159,145	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	7.23	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	159,145	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	303,333	0	303,333	0	303,333	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	188,444	0	188,444	0	188,444	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	180,557	0	180,557	0	180,557	9.00
10.00	Subtotal (sum of lines 1 through 9)	672,334	0	672,334	0	672,334	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	17,088	17,088	0	17,088	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,088	17,088	0	17,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	672,334	17,088	689,422	0	689,422	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	62,662	62,662	0	62,662	29.00
30.00	Administrative Costs	72,773	0	72,773	0	72,773	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,773	62,662	135,435	0	135,435	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	745,107	79,750	824,857	0	824,857	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	303,333		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	188,444		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	180,557		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	672,334		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	17,088		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,088		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	689,422		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	62,662		29.00
30.00	Administrative Costs	0	72,773		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	135,435		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	824,857		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061
Component CCN: 15-3999

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

Worksheet M-1
Date/Time Prepared: 5/31/2024 9:20 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	284,810	0	284,810	0	284,810	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	84,253	0	84,253	0	84,253	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	113,524	0	113,524	0	113,524	9.00
10.00	Subtotal (sum of lines 1 through 9)	482,587	0	482,587	0	482,587	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	29,456	29,456	0	29,456	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,456	29,456	0	29,456	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	482,587	29,456	512,043	0	512,043	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	41,485	41,485	0	41,485	29.00
30.00	Administrative Costs	76,136	0	76,136	0	76,136	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	76,136	41,485	117,621	0	117,621	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	558,723	70,941	629,664	0	629,664	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	284,810		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	84,253		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	113,524		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	482,587		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	29,456		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,456		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	512,043		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	41,485		29.00
30.00	Administrative Costs	0	76,136		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	117,621		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	629,664		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	635,457	0	635,457	0	635,457	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	286,495	0	286,495	0	286,495	9.00
10.00	Subtotal (sum of lines 1 through 9)	921,952	0	921,952	0	921,952	10.00
11.00	Physician Services Under Agreement	0	96,150	96,150	0	96,150	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	96,150	96,150	0	96,150	14.00
15.00	Medical Supplies	0	22,396	22,396	0	22,396	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,396	22,396	0	22,396	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	921,952	118,546	1,040,498	0	1,040,498	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	62,475	62,475	0	62,475	29.00
30.00	Administrative Costs	125,627	0	125,627	0	125,627	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	125,627	62,475	188,102	0	188,102	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,047,579	181,021	1,228,600	0	1,228,600	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	635,457		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	286,495		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	921,952		10.00
11.00	Physician Services Under Agreement	0	96,150		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	96,150		14.00
15.00	Medical Supplies	0	22,396		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,396		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,040,498		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	62,475		29.00
30.00	Administrative Costs	0	125,627		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	188,102		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,228,600		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	865,805	0	865,805	0	865,805	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	403,958	0	403,958	0	403,958	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	248,692	0	248,692	0	248,692	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,518,455	0	1,518,455	0	1,518,455	10.00
11.00	Physician Services Under Agreement	0	9,000	9,000	0	9,000	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	9,000	9,000	0	9,000	14.00
15.00	Medical Supplies	0	151,307	151,307	0	151,307	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	151,307	151,307	0	151,307	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,518,455	160,307	1,678,762	0	1,678,762	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	30,598	30,598	0	30,598	29.00
30.00	Administrative Costs	123,114	0	123,114	0	123,114	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	123,114	30,598	153,712	0	153,712	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,641,569	190,905	1,832,474	0	1,832,474	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 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	865,805		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	403,958		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	248,692		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,518,455		10.00
11.00	Physician Services Under Agreement	0	9,000		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	9,000		14.00
15.00	Medical Supplies	0	151,307		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	151,307		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,678,762		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	30,598		29.00
30.00	Administrative Costs	0	123,114		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	153,712		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,832,474		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061
Component CCN: 15-8506

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

Worksheet M-1
Date/Time Prepared: 5/31/2024 9:20 am

RHC VI | 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	204,965	0	204,965	0	204,965	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	114,726	0	114,726	0	114,726	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	164,156	0	164,156	0	164,156	9.00
10.00	Subtotal (sum of lines 1 through 9)	483,847	0	483,847	0	483,847	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	21,234	21,234	0	21,234	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,234	21,234	0	21,234	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	483,847	21,234	505,081	0	505,081	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	32,684	32,684	0	32,684	29.00
30.00	Administrative Costs	66,314	0	66,314	0	66,314	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	66,314	32,684	98,998	0	98,998	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	550,161	53,918	604,079	0	604,079	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 9:20 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	204,965		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	114,726		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	164,156		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	483,847		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	21,234		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,234		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	505,081		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	32,684		29.00
30.00	Administrative Costs	0	66,314		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	98,998		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	604,079		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 9:20 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.50	3,127	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.43	2,975	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.93	6,102		3	6,102	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.93	6,102			6,102	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)	689,422	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)	689,422	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)	135,435	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	551,613	15.00
16.00	Total overhead (sum of lines 14 and 15)	687,048	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	687,048	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	687,048	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,376,470	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-3999 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 Date/Time Prepared: 5/31/2024 9:20 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.74	1,532	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.61	1,271	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.35	2,803		2	2,803	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.35	2,803			2,803	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)	512,043	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)	512,043	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)	117,621	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	398,875	15.00
16.00	Total overhead (sum of lines 14 and 15)	516,496	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	516,496	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	516,496	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,028,539	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 9:20 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	0.27	554	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	6.91	14,383	1	7		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.18	14,937		7	14,937	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.18	14,937			14,937	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)	1,040,498	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)	1,040,498	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)	188,102	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	721,826	15.00
16.00	Total overhead (sum of lines 14 and 15)	909,928	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	909,928	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	909,928	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,950,426	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 9:20 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	0.95	1,983	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.02	4,205	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.97	6,188		3	6,188	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.97	6,188			6,188	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)	1,678,762	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)	1,678,762	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)	153,712	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	785,954	15.00
16.00	Total overhead (sum of lines 14 and 15)	939,666	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	939,666	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	939,666	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,618,428	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 9:20 am

RHC VI | 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	1.12	2,334	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.14	2,370	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.26	4,704		2	4,704	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.26	4,704			4,704	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)	505,081	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)	505,081	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)	98,998	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	352,558	15.00
16.00	Total overhead (sum of lines 14 and 15)	451,556	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	451,556	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	451,556	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	956,637	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 9:20 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)		1,376,470	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		2,110	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,374,360	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,102	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)		6,102	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		225.23	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	219.35	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	219.35	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	938	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	205,750	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	205,750	16.00
16.01	Total program charges (see instructions)(from contractor's records)		205,097	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,043	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,075	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.)		139,618	16.04
16.05	Total program cost (see instructions)	0	149,693	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,153	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,781	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		149,693	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,138	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		150,831	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)		150,831	26.00
26.01	Sequestration adjustment (see instructions)		3,017	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		146,002	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)		1,812	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: 15-0061 Component CCN: 15-3999	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 9:20 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)		1,028,539	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		1,095	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,027,444	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,803	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)		2,803	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		366.55	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	204.01	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	204.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	483	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	98,537	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	98,537	16.00
16.01	Total program charges (see instructions)(from contractor's records)		92,931	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,231	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,305	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.)		66,937	16.04
16.05	Total program cost (see instructions)	0	68,242	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,561	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,591	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		68,242	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		623	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		68,865	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)		68,865	26.00
26.01	Sequestration adjustment (see instructions)		1,377	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		66,795	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)		693	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: 15-0061 Component CCN: 15-8501	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,950,426	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		703	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,949,723	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,937	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)		14,937	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		130.53	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	156.85	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	130.53	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,312	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	171,255	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	171,255	16.00
16.01	Total program charges (see instructions)(from contractor's records)		237,838	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,897	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,526	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.)		102,654	16.04
16.05	Total program cost (see instructions)	0	106,180	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,411	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,681	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		106,180	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		449	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		106,629	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)		106,629	26.00
26.01	Sequestration adjustment (see instructions)		2,133	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		120,578	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)		-16,082	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: 15-0061 Component CCN: 15-8503	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 9:20 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)			2,618,428	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)			2,618,428	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,188	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)			6,188	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			423.15	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	335.83		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	335.83		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,015		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	2,015		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,129		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.)		1,431		16.04
16.05	Total program cost (see instructions)	0	1,431		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		226		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		181		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		1,431		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		1,431		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,431		26.00
26.01	Sequestration adjustment (see instructions)		29		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,302		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)		100		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: 15-0061 Component CCN: 15-8506	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 9:20 am
	Title XVIII	RHC VI	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)	956,637	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	1,553	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	955,084	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	4,704	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	4,704	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	203.04	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	198.37	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	198.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	971	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	192,617	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	192,617	16.00
16.01	Total program charges (see instructions)(from contractor's records)		176,522	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		506	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		552	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.)		131,589	16.04
16.05	Total program cost (see instructions)	0	132,141	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,579	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,688	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		132,141	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,079	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		133,220	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)		133,220	26.00
26.01	Sequestration adjustment (see instructions)		2,664	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		127,619	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)		2,937	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: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/31/2024 9:20 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)	672,334	672,334	672,334	672,334	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000123	0.001448	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	83	974	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	83	974	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	689,422	689,422	689,422	689,422	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	687,048	687,048	687,048	687,048	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000120	0.001413	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	82	971	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	165	1,945	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	94	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	20.63	20.69	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	53	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)	41	1,097	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)		2,110	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)		1,138	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 15-3999 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	482,587	482,587	482,587	482,587	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000136	0.000993	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	66	479	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	66	479	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	512,043	512,043	512,043	512,043	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	516,496	516,496	516,496	516,496	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000129	0.000935	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	67	483	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	133	962	0	0	10.00
11.00	Total number of injections/infusions (from your records)	7	51	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	19.00	18.86	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	29	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)	76	547	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)		1,095	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)		623	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 15-8501 | Date/Time Prepared: 5/31/2024 9:20 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)	921,952	921,952	921,952	921,952	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000017	0.000389	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	16	359	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16	359	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,040,498	1,040,498	1,040,498	1,040,498	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	909,928	909,928	909,928	909,928	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000015	0.000345	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	14	314	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	30	673	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	45	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	15.00	14.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	30	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	449	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)		703	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)		449	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 15-8506 | Date/Time Prepared: 5/31/2024 9:20 am

Title XVIII | RHC VI | 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)	483,847	483,847	483,847	483,847	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000054	0.001642	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	26	794	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	26	794	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	505,081	505,081	505,081	505,081	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	451,556	451,556	451,556	451,556	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000051	0.001572	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	23	710	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49	1,504	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	92	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	16.33	16.35	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	66	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	1,079	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)		1,553	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)		1,079	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 9:20 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		146,002	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)		146,002	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		1,812	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		147,814	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: 15-0061 Component CCN: 15-3999	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 9:20 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		66,795	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)		66,795	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		693	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		67,488	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: 15-0061 Component CCN: 15-8501	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 9:20 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		120,578	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)		120,578	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		16,082	6.02
7.00	Total Medicare program liability (see instructions)		104,496	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: 15-0061 Component CCN: 15-8503	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 9:20 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		1,302	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,302	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		100	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,402	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: 15-0061 Component CCN: 15-8506	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 9:20 am
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		127,619	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)		127,619	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		2,937	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		130,556	7.00

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