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: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 8:56 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 8:56 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 FRANCISCAN HEALTH RENSSELAER (15-1324) 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	Jason Geddes		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jason Geddes			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	386,272	-23,710	0	-143,289	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	186,627	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		6,012		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,647		0	10.01
200.00	TOTAL	0	572,899	-15,051	0	-143,289	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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:			1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978	County: JASPER	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	FRANCISCAN HEALTH RENSSELAER	151324	23844	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANCISCAN HEALTH RENSSELAER	15Z324	99915		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	BROOK	158502	99915		01/01/2005	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	46,989	0	34,720	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	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: FRANCISCAN ALLIANCE INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 W. DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	143.00

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

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

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

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

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00	169.00
			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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 8:56 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/17/2024	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	03/12/2024	Y	03/12/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG		YANG		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-407-6568		HONG.YANG@FRANCISCANALLIANCE.ORG		43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ADMINISTRATIVE 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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 8:56 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	28,824.00	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)		25	9,125	28,824.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	28,824.00	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						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:56 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)	528	8	894			1.00
2.00	HMO and other (see instructions)	206	67				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	287	0	287			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	140			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	815	8	1,321			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT	0	0	0			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)	815	8	1,321	0.00	118.01	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						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	254	418	769	0.00	2.76	26.00
26.01	RURAL HEALTH CLINIC II	504	508	1,697	0.00	3.21	26.01
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	123.98	27.00
28.00	Observation Bed Days		117	602			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:56 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	192	3	378	1.00
2.00	HMO and other (see instructions)			72	20		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	192	3	378	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:56 am

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			429 S BIERMA ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WHEATFIELD		IN	47978	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			07:00	16:30	07:00	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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:56 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	07:00	16:30			11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:56 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			420 E. MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BROOK		IN	47922	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			07:00	16:30	07:00	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: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:56 am

RHC II | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	07:00	16:30	07:00	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:56 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)	0.319291	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,085,724	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	0	5.00
6.00	Medicaid charges	18,961,059	6.00
7.00	Medicaid cost (line 1 times line 6)	6,054,095	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	968,371	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)	968,371	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)	2,877,577	0	2,877,577	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	918,784	0	918,784	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)	918,784	0	918,784	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)	1,020,591	26.00
27.00	Medicare reimbursable bad debts (see instructions)	498,078	27.00
27.01	Medicare allowable bad debts (see instructions)	766,274	27.01
28.00	Non-Medicare bad debt amount (see instructions)	254,317	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	349,397	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,268,181	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,236,552	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:56 am

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:56 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		1,182,616	1,182,616	83,834	1,266,450	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	989,286	989,286	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,610	2,661,940	2,679,550	0	2,679,550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	833,550	11,257,191	12,090,741	-192,724	11,898,017	5.00
7.00	00700	OPERATION OF PLANT	500,689	1,293,434	1,794,123	-51,626	1,742,497	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,517	305	6,822	0	6,822	8.00
9.00	00900	HOUSEKEEPING	395,819	164,337	560,156	-28,761	531,395	9.00
10.00	01000	DIETARY	236,198	231,232	467,430	-387,252	80,178	10.00
11.00	01100	CAFETERIA	0	0	0	378,901	378,901	11.00
13.00	01300	NURSING ADMINISTRATION	150,846	108,372	259,218	-101,984	157,234	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,150	47,250	63,400	-4,147	59,253	14.00
15.00	01500	PHARMACY	352,806	3,385,219	3,738,025	-3,339,285	398,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,796,122	350,409	2,146,531	-23,843	2,122,688	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	767,572	338,993	1,106,565	-174,377	932,188	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,206,451	372,150	1,578,601	-298,127	1,280,474	54.00
60.00	06000	LABORATORY	0	2,423,333	2,423,333	-49,833	2,373,500	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	227	227	37,878	38,105	63.00
65.00	06500	RESPIRATORY THERAPY	668,700	33,843	702,543	-30,775	671,768	65.00
66.00	06600	PHYSICAL THERAPY	480,231	30,152	510,383	-9,905	500,478	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	308,857	8,040	316,897	-2,307	314,590	66.01
67.00	06700	OCCUPATIONAL THERAPY	163,480	4,413	167,893	-984	166,909	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	90,987	5,451	96,438	-372	96,066	67.01
68.00	06800	SPEECH PATHOLOGY	105,885	2,366	108,251	0	108,251	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	154,036	4,806	158,842	-372	158,470	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,587	694,587	0	694,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	142,011	142,011	0	142,011	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,410,034	3,410,034	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	213,448	51,915	265,363	-21,823	243,540	88.00
88.01	08801	RURAL HEALTH CLINIC II	276,881	54,055	330,936	-46,676	284,260	88.01
90.00	09000	CLINIC	1,014,417	522,830	1,537,247	-112,737	1,424,510	90.00
90.01	09001	WOUND CARE	35,444	12,720	48,164	-3,886	44,278	90.01
91.00	09100	EMERGENCY	1,228,856	1,349,226	2,578,082	-18,137	2,559,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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		0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,021,552	26,733,423	37,754,975	0	37,754,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,015	3,015	0	3,015	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	11,021,552	26,736,438	37,757,990	0	37,757,990	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:56 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	299,445	1,565,895		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	989,286		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	88,104	2,767,654		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-657,003	11,241,014		5.00
7.00	00700	OPERATION OF PLANT	-11,781	1,730,716		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,822		8.00
9.00	00900	HOUSEKEEPING	0	531,395		9.00
10.00	01000	DIETARY	0	80,178		10.00
11.00	01100	CAFETERIA	-88,577	290,324		11.00
13.00	01300	NURSING ADMINISTRATION	192,308	349,542		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-84,143	-24,890		14.00
15.00	01500	PHARMACY	500,782	899,522		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-643,979	1,478,709		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-415,866	516,322		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,572	1,249,902		54.00
60.00	06000	LABORATORY	0	2,373,500		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	38,105		63.00
65.00	06500	RESPIRATORY THERAPY	-16,519	655,249		65.00
66.00	06600	PHYSICAL THERAPY	-1,862	498,616		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	314,590		66.01
67.00	06700	OCCUPATIONAL THERAPY	-889	166,020		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	96,066		67.01
68.00	06800	SPEECH PATHOLOGY	0	108,251		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	158,470		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,587		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	142,011		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,410,034		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
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	-7,432	236,108		88.00
88.01	08801	RURAL HEALTH CLINIC II	-150	284,110		88.01
90.00	09000	CLINIC	-413,824	1,010,686		90.00
90.01	09001	WOUND CARE	0	44,278		90.01
91.00	09100	EMERGENCY	-3,571	2,556,374		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
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	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,295,529	36,459,446		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,015		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	ALTERNACARE	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0		194.01
194.02	07952	UNUSED SPACE	0	0		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,295,529	36,462,461		200.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:56 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	191,025	187,876		1.00
	0		191,025	187,876		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46,306		1.00
	0		0	46,306		
	C - HOUSEKEEPING					
1.00	OPERATING ROOM	50.00	28,492	0		1.00
	0		28,492	0		
	D - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,410,034		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
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	0		0	3,410,034		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,528		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	845,027		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
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	882,555		
	F - CAPITAL LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	144,259		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
7.00		0.00	0	0		7.00
	TOTALS		0	144,259		
	G - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	32,825	5,280		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		32,825	5,280		
500.00	Grand Total: Increases		252,342	4,676,310		500.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	191,025	187,876	0		1.00
	0		191,025	187,876			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,306	12		1.00
	0		0	46,306			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	28,492	0	0		1.00
	0		28,492	0			
	D - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	379	0		2.00
3.00	PHARMACY	15.00	0	3,316,941	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	265	0		4.00
5.00	OPERATING ROOM	50.00	0	3,892	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,587	0		6.00
7.00	LABORATORY	60.00	0	187	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	188	0		8.00
9.00	PHYSICAL THERAPY- WHEATFIELD	66.01	0	367	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	0	21,823	0		10.00
11.00	RURAL HEALTH CLINIC II	88.01	0	30,461	0		11.00
12.00	WOUND CARE	90.01	0	213	0		12.00
13.00	EMERGENCY	91.00	0	704	0		13.00
	0		0	3,410,034			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	128,526	9		1.00
2.00	OPERATION OF PLANT	7.00	0	35,936	9		2.00
3.00	HOUSEKEEPING	9.00	0	269	0		3.00
4.00	DIETARY	10.00	0	8,351	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	100,860	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,768	0		6.00
7.00	PHARMACY	15.00	0	7,496	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	3,672	0		8.00
9.00	OPERATING ROOM	50.00	0	107,500	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	263,540	0		10.00
11.00	LABORATORY	60.00	0	49,646	0		11.00
12.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	227	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	30,775	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	8,681	0		14.00
15.00	PHYSICAL THERAPY- WHEATFIELD	66.01	0	1,940	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	984	0		16.00
17.00	OCCUPATIONAL THERAPY-WHEATFIELD	67.01	0	372	0		17.00
18.00	SPEECH PATHOLOGY- WHEATFIELD	68.01	0	372	0		18.00
19.00	RURAL HEALTH CLINIC II	88.01	0	16,215	0		19.00
20.00	CLINIC	90.00	0	97,212	0		20.00
21.00	WOUND CARE	90.01	0	3,673	0		21.00
22.00	EMERGENCY	91.00	0	12,540	0		22.00
	TOTALS		0	882,555			
	F - CAPITAL LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,865	10		1.00
2.00	OPERATION OF PLANT	7.00	0	15,690	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	1,124	0		3.00
4.00	PHARMACY	15.00	0	14,848	0		4.00
5.00	OPERATING ROOM	50.00	0	91,477	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1,036	0		6.00
7.00	CLINIC	90.00	0	2,219	0		7.00
	TOTALS		0	144,259			
	G - BLOOD						
1.00	ADULTS & PEDIATRICS	30.00	15,742	4,164	0		1.00
2.00	CLINIC	90.00	13,173	133	0		2.00
3.00	EMERGENCY	91.00	3,910	983	0		3.00
	TOTALS		32,825	5,280			
500.00	Grand Total: Decreases		252,342	4,676,310			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2024 8:56 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	675,791	0	0	0	0	1.00
2.00	Land Improvements	509,926	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,098,672	1,200,656	0	1,200,656	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,700,733	23,479	0	23,479	4,258,473	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,985,122	1,224,135	0	1,224,135	4,258,473	8.00
9.00	Reconciling Items	-335,831	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,320,953	1,224,135	0	1,224,135	4,258,473	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,791	0	1.00
2.00	Land Improvements	509,926	0	2.00
3.00	Buildings and Fixtures	21,299,328	42,854	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,465,739	3,424,105	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,950,784	3,466,959	8.00
9.00	Reconciling Items	-335,831	-176,678	9.00
10.00	Total (line 8 minus line 9)	30,286,615	3,643,637	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 8:56 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	196,786	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	196,786	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	985,830	1,182,616		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	985,830	1,182,616		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 8:56 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	21,284,389	0	21,284,389	0.645272	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,700,733	0	11,700,733	0.354728	0	2.00
3.00	Total (sum of lines 1-2)	32,985,122	0	32,985,122	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	242,753	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	845,027	144,259	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,087,780	144,259	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	46,306	0	1,276,836	1,565,895	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	989,286	2.00
3.00	Total (sum of lines 1-2)	0	46,306	0	1,276,836	2,555,181	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:56 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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-84,143	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,518,339			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	2,519,542			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-70,483	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-2,050	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:56 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HAF OFFSET	A	-1,991,627	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE	B	-123,114	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	OTHER REVENUE	B	-7,282	RURAL HEALTH CLINIC	88.00	0	34.01
34.02	OTHER REVENUE	B	-6,456	PHARMACY	15.00	0	34.02
34.03	OTHER REVENUE	B	-3,535	EMERGENCY	91.00	0	34.03
34.04	OTHER REVENUE	B	-16,044	CAFETERIA	11.00	0	34.04
34.05	OTHER REVENUE	B	-741	OPERATION OF PLANT	7.00	0	34.05
35.00	LOBBYING	A	-1,251	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	DEPRECIATION CARRYFORWARD	A	8,439	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	MARKETING / ADVERTISING	A	-812	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MARKETING / ADVERTISING	A	-11,040	OPERATION OF PLANT	7.00	0	38.00
38.01	MARKETING / ADVERTISING	A	-33	ADULTS & PEDIATRICS	30.00	0	38.01
38.02	MARKETING / ADVERTISING	A	-36	EMERGENCY	91.00	0	38.02
38.03	MARKETING / ADVERTISING	A	-2,347	RADIOLOGY-DIAGNOSTIC	54.00	0	38.03
38.04	MARKETING / ADVERTISING	A	-1,862	PHYSICAL THERAPY	66.00	0	38.04
38.05	MARKETING / ADVERTISING	A	-889	OCCUPATIONAL THERAPY	67.00	0	38.05
38.06	MARKETING / ADVERTISING	A	-150	RURAL HEALTH CLINIC	88.00	0	38.06
38.07	MARKETING / ADVERTISING	A	-150	RURAL HEALTH CLINIC II	88.01	0	38.07
38.08	MARKETING / ADVERTISING	A	-41	CLINIC	90.00	0	38.08
39.00	PHYSICIAN RHC SALARY	A	0	RURAL HEALTH CLINIC	88.00	0	39.00
39.01	PHYSICIAN RHC SALARY	A	0	RURAL HEALTH CLINIC II	88.01	0	39.01
40.00	PENSION	A	18,915	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,295,529				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 8:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	291,006	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	6,459,857	6,520,565	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	69,189	0	3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	1,520,509	0	3.02
3.04	13.00	NURSING ADMINISTRATION	SHARED SERVICES	192,308	0	3.04
3.05	15.00	PHARMACY	SHARED SERVICES	507,238	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.09	0.00			0	0	3.09
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,040,107	6,520,565	5.00

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

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

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

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

6.00	B	FRANCISCAN ALLI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 8:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	291,006	14		1.00
2.00	-60,708	0		2.00
3.00	69,189	0		3.00
3.02	1,520,509	0		3.02
3.04	192,308	0		3.04
3.05	507,238	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.09	0	0		3.09
4.00	0	0		4.00
4.01	0	0		4.01
5.00	2,519,542			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 8:56 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	5.00	ADMINISTRATIVE & GENERAL	77,777	0	77,777	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	643,946	643,946	0	0	0	2.00
3.00	50.00	OPERATING ROOM	415,866	415,866	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	28,225	28,225	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	16,519	16,519	0	0	0	5.00
6.00	90.00	CLINIC	413,783	413,783	0	0	0	6.00
7.00	90.01	WOUND CARE	8,609	0	8,609	0	0	7.00
8.00	91.00	EMERGENCY	1,033,304	0	1,033,304	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,638,029	1,518,339	1,119,690		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	643,946		2.00
3.00	50.00	OPERATING ROOM	0	0	0	415,866		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	28,225		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	16,519		5.00
6.00	90.00	CLINIC	0	0	0	413,783		6.00
7.00	90.01	WOUND CARE	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,518,339		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 8:56 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	1,565,895	1,565,895				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	989,286		989,286			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,767,654	9,576	6,292	2,783,522		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,241,014	184,830	121,445	210,852	11,758,141	5.00
7.00	00700	OPERATION OF PLANT	1,730,716	197,548	129,803	126,653	2,184,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,822	18,841	12,380	1,649	39,692	8.00
9.00	00900	HOUSEKEEPING	531,395	24,393	16,028	92,918	664,734	9.00
10.00	01000	DIETARY	80,178	22,149	14,553	11,427	128,307	10.00
11.00	01100	CAFETERIA	290,324	27,748	18,233	48,321	384,626	11.00
13.00	01300	NURSING ADMINISTRATION	349,542	1,528	1,004	38,158	390,232	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-24,890	51,306	33,711	4,085	64,212	14.00
15.00	01500	PHARMACY	899,522	13,074	8,591	89,245	1,010,432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,211	12,623	0	31,834	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,478,709	122,694	80,618	450,357	2,132,378	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	516,322	109,167	71,730	201,370	898,589	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,902	70,051	46,028	305,180	1,671,161	54.00
60.00	06000	LABORATORY	2,373,500	33,766	22,187	0	2,429,453	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	38,105	1,218	800	8,303	48,426	63.00
65.00	06500	RESPIRATORY THERAPY	655,249	47,079	30,934	169,152	902,414	65.00
66.00	06600	PHYSICAL THERAPY	498,616	89,657	58,910	121,478	768,661	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	314,590	109,381	71,871	78,128	573,970	66.01
67.00	06700	OCCUPATIONAL THERAPY	166,020	5,146	3,381	41,353	215,900	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	96,066	23,522	15,455	23,016	158,059	67.01
68.00	06800	SPEECH PATHOLOGY	108,251	4,358	2,864	26,784	142,257	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	158,470	15,259	10,026	38,964	222,719	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	694,587	0	0	0	694,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,011	0	0	0	142,011	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,410,034	0	0	0	3,410,034	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	236,108	17,910	11,768	53,993	319,779	88.00
88.01	08801	RURAL HEALTH CLINIC II	284,110	24,739	16,255	70,039	395,143	88.01
90.00	09000	CLINIC	1,010,686	154,335	101,409	253,272	1,519,702	90.00
90.01	09001	WOUND CARE	44,278	12,871	8,457	8,966	74,572	90.01
91.00	09100	EMERGENCY	2,556,374	90,970	59,773	309,859	3,016,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,459,446	1,502,327	987,129	2,783,522	36,393,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,015	3,283	2,157	0	8,455	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	60,285	0	0	60,285	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,462,461	1,565,895	989,286	2,783,522	36,462,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,758,141					5.00
7.00	00700	OPERATION OF PLANT	1,039,828	3,224,548				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,892	51,752	110,336			8.00
9.00	00900	HOUSEKEEPING	316,383	67,002	0	1,048,119		9.00
10.00	01000	DIETARY	61,068	60,837	0	20,531	270,743	10.00
11.00	01100	CAFETERIA	183,065	76,218	0	25,722	0	11.00
13.00	01300	NURSING ADMINISTRATION	185,733	4,198	0	1,417	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,562	140,925	11,222	47,558	0	14.00
15.00	01500	PHARMACY	480,920	35,912	0	12,119	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,152	52,769	0	17,808	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,014,916	337,013	15,040	113,733	270,743	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,688	299,855	81,189	101,193	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	795,397	192,415	2,072	64,935	0	54.00
60.00	06000	LABORATORY	1,156,310	92,747	0	31,300	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,049	3,345	0	1,129	0	63.00
65.00	06500	RESPIRATORY THERAPY	429,508	129,315	0	43,640	0	65.00
66.00	06600	PHYSICAL THERAPY	365,848	246,266	0	83,108	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	273,184	300,445	0	101,392	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	102,759	14,135	0	4,770	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	75,229	64,608	0	21,804	0	67.01
68.00	06800	SPEECH PATHOLOGY	67,708	11,971	0	4,040	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	106,004	41,913	0	14,145	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	330,592	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,591	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,623,020	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	152,200	49,194	0	16,602	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	188,070	67,954	0	22,932	0	88.01
90.00	09000	CLINIC	723,310	423,924	0	143,060	0	90.00
90.01	09001	WOUND CARE	35,493	35,354	0	11,931	0	90.01
91.00	09100	EMERGENCY	1,435,945	249,874	813	84,325	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,725,424	3,049,941	110,336	989,194	270,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,024	9,019	0	3,044	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	28,693	165,588	0	55,881	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	11,758,141	3,224,548	110,336	1,048,119	270,743	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	669,631					11.00
13.00	01300	NURSING ADMINISTRATION	11,788	593,368				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,262	0	295,741			14.00
15.00	01500	PHARMACY	27,569	0	0	1,566,952		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	117,563	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,351	177,774	0	0	3,542	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,207	46,487	0	0	3,091	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,276	65,955	0	0	18,121	54.00
60.00	06000	LABORATORY	0	0	0	0	15,592	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	324	63.00
65.00	06500	RESPIRATORY THERAPY	52,254	0	0	0	3,199	65.00
66.00	06600	PHYSICAL THERAPY	37,527	0	0	0	3,370	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	24,135	0	0	0	2,206	66.01
67.00	06700	OCCUPATIONAL THERAPY	12,775	0	0	0	785	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	7,110	0	0	0	379	67.01
68.00	06800	SPEECH PATHOLOGY	8,274	0	0	0	325	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	12,037	0	0	0	682	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	245,540	0	5,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,201	0	1,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,566,952	41,343	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	158	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	282	88.01
90.00	09000	CLINIC	79,270	145,013	0	0	6,138	90.00
90.01	09001	WOUND CARE	2,770	0	0	0	635	90.01
91.00	09100	EMERGENCY	96,026	158,139	0	0	10,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	669,631	593,368	295,741	1,566,952	117,563	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	669,631	593,368	295,741	1,566,952	117,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,205,490	0	4,205,490		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,920,299	0	1,920,299		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,904,332	0	2,904,332		54.00
60.00	06000	LABORATORY	3,725,402	0	3,725,402		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	76,273	0	76,273		63.00
65.00	06500	RESPIRATORY THERAPY	1,560,330	0	1,560,330		65.00
66.00	06600	PHYSICAL THERAPY	1,504,780	0	1,504,780		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,275,332	0	1,275,332		66.01
67.00	06700	OCCUPATIONAL THERAPY	351,124	0	351,124		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	327,189	0	327,189		67.01
68.00	06800	SPEECH PATHOLOGY	234,575	0	234,575		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	397,500	0	397,500		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,275,940	0	1,275,940		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	261,670	0	261,670		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,641,349	0	6,641,349		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	537,933	0	537,933		88.00
88.01	08801	RURAL HEALTH CLINIC II	674,381	0	674,381		88.01
90.00	09000	CLINIC	3,040,417	0	3,040,417		90.00
90.01	09001	WOUND CARE	160,755	0	160,755		90.01
91.00	09100	EMERGENCY	5,052,401	0	5,052,401		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,127,472	0	36,127,472		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,542	0	24,542		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	ALTERNACARE	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0		194.01
194.02	07952	UNUSED SPACE	310,447	0	310,447		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	36,462,461	0	36,462,461		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:56 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	9,576	6,292	15,868	15,868	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	184,830	121,445	306,275	1,202	5.00
7.00	00700	OPERATION OF PLANT	0	197,548	129,803	327,351	722	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,841	12,380	31,221	9	8.00
9.00	00900	HOUSEKEEPING	0	24,393	16,028	40,421	530	9.00
10.00	01000	DIETARY	0	22,149	14,553	36,702	65	10.00
11.00	01100	CAFETERIA	0	27,748	18,233	45,981	275	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,528	1,004	2,532	218	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,306	33,711	85,017	23	14.00
15.00	01500	PHARMACY	0	13,074	8,591	21,665	509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,211	12,623	31,834	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	122,694	80,618	203,312	2,569	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	109,167	71,730	180,897	1,148	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,051	46,028	116,079	1,740	54.00
60.00	06000	LABORATORY	0	33,766	22,187	55,953	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,218	800	2,018	47	63.00
65.00	06500	RESPIRATORY THERAPY	0	47,079	30,934	78,013	964	65.00
66.00	06600	PHYSICAL THERAPY	0	89,657	58,910	148,567	692	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	109,381	71,871	181,252	445	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,146	3,381	8,527	236	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	23,522	15,455	38,977	131	67.01
68.00	06800	SPEECH PATHOLOGY	0	4,358	2,864	7,222	153	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	15,259	10,026	25,285	222	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	17,910	11,768	29,678	308	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	24,739	16,255	40,994	399	88.01
90.00	09000	CLINIC	0	154,335	101,409	255,744	1,444	90.00
90.01	09001	WOUND CARE	0	12,871	8,457	21,328	51	90.01
91.00	09100	EMERGENCY	0	90,970	59,773	150,743	1,766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,502,327	987,129	2,489,456	15,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,283	2,157	5,440	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	60,285	0	60,285	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,565,895	989,286	2,555,181	15,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	307,477					5.00
7.00	00700	OPERATION OF PLANT	27,191	355,264				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	494	5,702	37,426			8.00
9.00	00900	HOUSEKEEPING	8,273	7,382	0	56,606		9.00
10.00	01000	DIETARY	1,597	6,703	0	1,109	46,176	10.00
11.00	01100	CAFETERIA	4,787	8,397	0	1,389	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,857	463	0	77	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	799	15,526	3,806	2,568	0	14.00
15.00	01500	PHARMACY	12,576	3,957	0	655	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396	5,814	0	962	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,540	37,130	5,101	6,142	46,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,184	33,036	27,540	5,465	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,799	21,199	703	3,507	0	54.00
60.00	06000	LABORATORY	30,237	10,218	0	1,690	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	603	369	0	61	0	63.00
65.00	06500	RESPIRATORY THERAPY	11,231	14,247	0	2,357	0	65.00
66.00	06600	PHYSICAL THERAPY	9,567	27,132	0	4,488	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	7,144	33,102	0	5,476	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,687	1,557	0	258	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,967	7,118	0	1,178	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,771	1,319	0	218	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	2,772	4,618	0	764	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,645	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,767	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,449	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,980	5,420	0	897	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,918	7,487	0	1,239	0	88.01
90.00	09000	CLINIC	18,914	46,705	0	7,726	0	90.00
90.01	09001	WOUND CARE	928	3,895	0	644	0	90.01
91.00	09100	EMERGENCY	37,549	27,530	276	4,554	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	306,622	336,026	37,426	53,424	46,176	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105	994	0	164	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	750	18,244	0	3,018	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	307,477	355,264	37,426	56,606	46,176	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	60,829					11.00
13.00	01300	NURSING ADMINISTRATION	1,071	9,218				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115	0	99,481			14.00
15.00	01500	PHARMACY	2,504	0	0	41,866		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	39,006	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,754	2,761	0	0	1,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,650	722	0	0	1,026	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,563	1,025	0	0	6,017	54.00
60.00	06000	LABORATORY	0	0	0	0	5,177	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	108	63.00
65.00	06500	RESPIRATORY THERAPY	4,746	0	0	0	1,062	65.00
66.00	06600	PHYSICAL THERAPY	3,409	0	0	0	1,119	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	2,192	0	0	0	733	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,160	0	0	0	261	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	646	0	0	0	126	67.01
68.00	06800	SPEECH PATHOLOGY	752	0	0	0	108	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,093	0	0	0	226	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	82,594	0	1,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,887	0	620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	41,866	13,697	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	52	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	94	88.01
90.00	09000	CLINIC	7,200	2,253	0	0	2,038	90.00
90.01	09001	WOUND CARE	252	0	0	0	211	90.01
91.00	09100	EMERGENCY	8,722	2,457	0	0	3,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,829	9,218	99,481	41,866	39,006	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	8,373	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,829	9,218	107,854	41,866	39,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	343,661	0	343,661		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	266,668	0	266,668		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,632	0	179,632		54.00
60.00	06000	LABORATORY	103,275	0	103,275		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,206	0	3,206		63.00
65.00	06500	RESPIRATORY THERAPY	112,620	0	112,620		65.00
66.00	06600	PHYSICAL THERAPY	194,974	0	194,974		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	230,344	0	230,344		66.01
67.00	06700	OCCUPATIONAL THERAPY	14,686	0	14,686		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	50,143	0	50,143		67.01
68.00	06800	SPEECH PATHOLOGY	11,543	0	11,543		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	34,980	0	34,980		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,973	0	92,973		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,274	0	19,274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,012	0	98,012		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	40,335	0	40,335		88.00
88.01	08801	RURAL HEALTH CLINIC II	55,131	0	55,131		88.01
90.00	09000	CLINIC	342,024	0	342,024		90.00
90.01	09001	WOUND CARE	27,309	0	27,309		90.01
91.00	09100	EMERGENCY	237,018	0	237,018		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,457,808	0	2,457,808		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,703	0	6,703		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	ALTERNACARE	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0		194.01
194.02	07952	UNUSED SPACE	82,297	0	82,297		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	8,373	0	8,373		201.00
202.00		TOTAL (sum lines 118 through 201)	2,555,181	0	2,555,181		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	131,148					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		126,099				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	802	802	11,003,942			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,480	15,480	833,550	-11,758,141	24,704,320	5.00
7.00	00700	OPERATION OF PLANT	16,545	16,545	500,689	0	2,184,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	1,578	6,517	0	39,692	8.00
9.00	00900	HOUSEKEEPING	2,043	2,043	367,327	0	664,734	9.00
10.00	01000	DIETARY	1,855	1,855	45,173	0	128,307	10.00
11.00	01100	CAFETERIA	2,324	2,324	191,025	0	384,626	11.00
13.00	01300	NURSING ADMINISTRATION	128	128	150,846	0	390,232	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	4,297	16,150	0	64,212	14.00
15.00	01500	PHARMACY	1,095	1,095	352,806	0	1,010,432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	1,609	0	0	31,834	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,276	10,276	1,780,380	0	2,132,378	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	9,143	796,064	0	898,589	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,867	5,867	1,206,451	0	1,671,161	54.00
60.00	06000	LABORATORY	2,828	2,828	0	0	2,429,453	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	102	102	32,825	0	48,426	63.00
65.00	06500	RESPIRATORY THERAPY	3,943	3,943	668,700	0	902,414	65.00
66.00	06600	PHYSICAL THERAPY	7,509	7,509	480,231	0	768,661	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,161	9,161	308,857	0	573,970	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	431	163,480	0	215,900	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	1,970	90,987	0	158,059	67.01
68.00	06800	SPEECH PATHOLOGY	365	365	105,885	0	142,257	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	1,278	154,036	0	222,719	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	694,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	142,011	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,410,034	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	1,500	1,500	213,448	0	319,779	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,072	2,072	276,881	0	395,143	88.01
90.00	09000	CLINIC	12,926	12,926	1,001,244	0	1,519,702	90.00
90.01	09001	WOUND CARE	1,078	1,078	35,444	0	74,572	90.01
91.00	09100	EMERGENCY	7,619	7,619	1,224,946	0	3,016,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,824	125,824	11,003,942	-11,758,141	24,635,580	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	275	0	0	8,455	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	5,049	0	0	0	60,285	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,565,895	989,286	2,783,522		11,758,141	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.939908	7.845312	0.252957		0.475955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,868		307,477	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001442		0.012446	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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	98,321					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	164,142				8.00
9.00	00900	HOUSEKEEPING	2,043	0	94,700			9.00
10.00	01000	DIETARY	1,855	0	1,855	10,750		10.00
11.00	01100	CAFETERIA	2,324	0	2,324	0	8,569,332	11.00
13.00	01300	NURSING ADMINISTRATION	128	0	128	0	150,846	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	16,694	4,297	0	16,150	14.00
15.00	01500	PHARMACY	1,095	0	1,095	0	352,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	0	1,609	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,276	22,374	10,276	10,750	1,796,122	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	120,783	9,143	0	796,064	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,867	3,082	5,867	0	1,206,451	54.00
60.00	06000	LABORATORY	2,828	0	2,828	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	102	0	102	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,943	0	3,943	0	668,700	65.00
66.00	06600	PHYSICAL THERAPY	7,509	0	7,509	0	480,231	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,161	0	9,161	0	308,857	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	0	431	0	163,480	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	0	1,970	0	90,987	67.01
68.00	06800	SPEECH PATHOLOGY	365	0	365	0	105,885	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	0	1,278	0	154,036	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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	1,500	0	1,500	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,072	0	2,072	0	0	88.01
90.00	09000	CLINIC	12,926	0	12,926	0	1,014,417	90.00
90.01	09001	WOUND CARE	1,078	0	1,078	0	35,444	90.01
91.00	09100	EMERGENCY	7,619	1,209	7,619	0	1,228,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,997	164,142	89,376	10,750	8,569,332	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	0	275	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	5,049	0	5,049	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,224,548	110,336	1,048,119	270,743	669,631	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.796127	0.672198	11.067782	25.185395	0.078143	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	355,264	37,426	56,606	46,176	60,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.613307	0.228010	0.597740	4.295442	0.007098	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	103,658					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	836,598				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	113,149,038		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,056	0	0	3,409,151		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,121	0	0	2,974,829		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,522	0	0	17,440,885		54.00
60.00	06000	LABORATORY	0	0	0	15,006,714		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	311,667		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,079,178		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,243,245		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	2,123,207		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	755,604		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	364,836		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	312,728		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	656,463		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,587	0	5,024,666		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	142,011	0	1,797,133		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	39,790,173		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	152,128		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	271,411		88.01
90.00	09000	CLINIC	25,333	0	0	5,907,977		90.00
90.01	09001	WOUND CARE	0	0	0	610,760		90.01
91.00	09100	EMERGENCY	27,626	0	0	9,916,283		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,658	836,598	100	113,149,038		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	ALTERNACARE	0	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0		194.01
194.02	07952	UNUSED SPACE	0	0	0	0		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0		194.03
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)	593,368	295,741	1,566,952	117,563		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.724286	0.353504	15,669.520000	0.001039		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,218	107,854	41,866	39,006		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.088927	0.118911	418.660000	0.000345		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:56 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,205,490		4,205,490	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,920,299		1,920,299	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,904,332		2,904,332	0	0	54.00
60.00	06000	LABORATORY	3,725,402		3,725,402	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	76,273		76,273	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,560,330	0	1,560,330	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,504,780	0	1,504,780	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,275,332	0	1,275,332	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	351,124	0	351,124	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	327,189	0	327,189	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	234,575	0	234,575	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	397,500	0	397,500	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,275,940		1,275,940	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	261,670		261,670	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,641,349		6,641,349	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
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	537,933		537,933	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	674,381		674,381	0	0	88.01
90.00	09000	CLINIC	3,040,417		3,040,417	0	0	90.00
90.01	09001	WOUND CARE	160,755		160,755	0	0	90.01
91.00	09100	EMERGENCY	5,052,401		5,052,401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,408,078		1,408,078		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	37,535,550	0	37,535,550	0	0	200.00
201.00		Less Observation Beds	1,408,078		1,408,078		0	201.00
202.00		Total (see instructions)	36,127,472	0	36,127,472	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,217,477		2,217,477			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,373	2,823,456	2,974,829	0.645516	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,513	17,046,372	17,440,885	0.166524	0.000000	54.00
60.00	06000	LABORATORY	1,196,842	13,809,872	15,006,714	0.248249	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	31,337	280,330	311,667	0.244726	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	344,761	2,734,417	3,079,178	0.506736	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	149,168	3,094,077	3,243,245	0.463974	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	225	2,122,982	2,123,207	0.600663	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	165,407	590,197	755,604	0.464693	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	364,836	364,836	0.896811	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	20,322	292,406	312,728	0.750093	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	656,463	656,463	0.605518	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	287,253	4,737,413	5,024,666	0.253935	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,662	1,747,471	1,797,133	0.145604	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,549	38,640,624	39,790,173	0.166909	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
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	152,128	152,128			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	271,411	271,411			88.01
90.00	09000	CLINIC	21,233	5,886,744	5,907,977	0.514629	0.000000	90.00
90.01	09001	WOUND CARE	0	610,760	610,760	0.263205	0.000000	90.01
91.00	09100	EMERGENCY	242,692	9,673,591	9,916,283	0.509506	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,344	1,124,330	1,191,674	1.181597	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,489,158	106,659,880	113,149,038			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,489,158	106,659,880	113,149,038			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0.000000	74.00
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
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:56 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	4,205,490		4,205,490	0	4,205,490	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,920,299		1,920,299	0	1,920,299	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,904,332		2,904,332	0	2,904,332	54.00
60.00	06000	LABORATORY	3,725,402		3,725,402	0	3,725,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	76,273		76,273	0	76,273	63.00
65.00	06500	RESPIRATORY THERAPY	1,560,330	0	1,560,330	0	1,560,330	65.00
66.00	06600	PHYSICAL THERAPY	1,504,780	0	1,504,780	0	1,504,780	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,275,332	0	1,275,332	0	1,275,332	66.01
67.00	06700	OCCUPATIONAL THERAPY	351,124	0	351,124	0	351,124	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	327,189	0	327,189	0	327,189	67.01
68.00	06800	SPEECH PATHOLOGY	234,575	0	234,575	0	234,575	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	397,500	0	397,500	0	397,500	68.01
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,275,940		1,275,940	0	1,275,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	261,670		261,670	0	261,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,641,349		6,641,349	0	6,641,349	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
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	537,933		537,933	0	537,933	88.00
88.01	08801	RURAL HEALTH CLINIC II	674,381		674,381	0	674,381	88.01
90.00	09000	CLINIC	3,040,417		3,040,417	0	3,040,417	90.00
90.01	09001	WOUND CARE	160,755		160,755	0	160,755	90.01
91.00	09100	EMERGENCY	5,052,401		5,052,401	0	5,052,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,408,078		1,408,078		1,408,078	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	37,535,550	0	37,535,550	0	37,535,550	200.00
201.00		Less Observation Beds	1,408,078		1,408,078		1,408,078	201.00
202.00		Total (see instructions)	36,127,472	0	36,127,472	0	36,127,472	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 8:56 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	2,217,477		2,217,477			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,373	2,823,456	2,974,829	0.645516	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,513	17,046,372	17,440,885	0.166524	0.000000	54.00
60.00	06000	LABORATORY	1,196,842	13,809,872	15,006,714	0.248249	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	31,337	280,330	311,667	0.244726	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	344,761	2,734,417	3,079,178	0.506736	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	149,168	3,094,077	3,243,245	0.463974	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	225	2,122,982	2,123,207	0.600663	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	165,407	590,197	755,604	0.464693	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	364,836	364,836	0.896811	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	20,322	292,406	312,728	0.750093	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	656,463	656,463	0.605518	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	287,253	4,737,413	5,024,666	0.253935	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,662	1,747,471	1,797,133	0.145604	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,549	38,640,624	39,790,173	0.166909	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
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	152,128	152,128	3.536055	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	271,411	271,411	2.484722	0.000000	88.01
90.00	09000	CLINIC	21,233	5,886,744	5,907,977	0.514629	0.000000	90.00
90.01	09001	WOUND CARE	0	610,760	610,760	0.263205	0.000000	90.01
91.00	09100	EMERGENCY	242,692	9,673,591	9,916,283	0.509506	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,344	1,124,330	1,191,674	1.181597	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
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
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,489,158	106,659,880	113,149,038			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,489,158	106,659,880	113,149,038			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:56 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
32.00	03200	CORONARY CARE UNIT		32.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0.000000	74.00
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
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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 ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	266,668	2,974,829	0.089641	51,728	4,637	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,632	17,440,885	0.010299	143,585	1,479	54.00
60.00	06000	LABORATORY	103,275	15,006,714	0.006882	607,653	4,182	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,206	311,667	0.010287	21,362	220	63.00
65.00	06500	RESPIRATORY THERAPY	112,620	3,079,178	0.036575	116,449	4,259	65.00
66.00	06600	PHYSICAL THERAPY	194,974	3,243,245	0.060117	47,847	2,876	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	230,344	2,123,207	0.108489	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,686	755,604	0.019436	52,349	1,017	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	50,143	364,836	0.137440	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	11,543	312,728	0.036911	6,426	237	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	34,980	656,463	0.053286	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,973	5,024,666	0.018503	147,665	2,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,274	1,797,133	0.010725	45,836	492	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,012	39,790,173	0.002463	460,696	1,135	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
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	40,335	152,128	0.265139	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	55,131	271,411	0.203127	0	0	88.01
90.00	09000	CLINIC	342,024	5,907,977	0.057892	15,272	884	90.00
90.01	09001	WOUND CARE	27,309	610,760	0.044713	0	0	90.01
91.00	09100	EMERGENCY	237,018	9,916,283	0.023902	76,536	1,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,064	1,191,674	0.096557	2,773	268	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	2,229,211	110,931,561		1,796,177	26,247	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,974,829	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,440,885	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,006,714	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	311,667	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,079,178	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,243,245	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	2,123,207	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	755,604	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	364,836	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	312,728	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	656,463	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,024,666	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,797,133	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,790,173	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
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	152,128	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	271,411	0.000000	88.01
90.00	09000	CLINIC	0	0	0	5,907,977	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	610,760	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	9,916,283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,191,674	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	110,931,561		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	51,728	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	143,585	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	607,653	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	21,362	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	116,449	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	47,847	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	52,349	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	6,426	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	147,665	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	45,836	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	460,696	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
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
90.00	09000	CLINIC	0.000000	15,272	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	76,536	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,773	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		1,796,177	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.645516	0	929,769	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166524	0	4,477,183	0	0	54.00
60.00	06000	LABORATORY	0.248249	0	2,404,841	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.244726	0	251,876	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.506736	0	946,955	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.463974	0	986,968	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.600663	0	647,731	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.464693	0	78,768	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.896811	0	28,595	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.750093	0	24,109	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.605518	0	4,230	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.253935	0	1,277,438	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.145604	0	668,402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166909	0	13,831,575	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
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
90.00	09000	CLINIC	0.514629	0	2,106,981	0	0	90.00
90.01	09001	WOUND CARE	0.263205	0	364,918	0	0	90.01
91.00	09100	EMERGENCY	0.509506	0	2,282,710	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.181597	0	341,938	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	31,654,987	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	31,654,987	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	600,181	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	745,558	0		54.00
60.00	06000	LABORATORY	596,999	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61,641	0		63.00
65.00	06500	RESPIRATORY THERAPY	479,856	0		65.00
66.00	06600	PHYSICAL THERAPY	457,927	0		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	389,068	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	36,603	0		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	25,644	0		67.01
68.00	06800	SPEECH PATHOLOGY	18,084	0		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	2,561	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,386	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,322	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,308,614	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
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
90.00	09000	CLINIC	1,084,314	0		90.00
90.01	09001	WOUND CARE	96,048	0		90.01
91.00	09100	EMERGENCY	1,163,054	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	404,033	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	8,891,893	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,891,893	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:56 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	0.645516	0	401,312	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166524	0	3,439,609	0	0	54.00
60.00	06000	LABORATORY	0.248249	0	3,157,144	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.244726	0	10,066	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.506736	0	475,057	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.463974	0	422,388	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.600663	0	393,578	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.464693	0	200,053	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.896811	0	126,911	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.750093	0	166,182	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.605518	0	169,629	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.253935	0	691,689	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.145604	0	224,659	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166909	0	4,708,799	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
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
90.00	09000	CLINIC	0.514629	0	615,375	0	0	90.00
90.01	09001	WOUND CARE	0.263205	0	6,874	0	0	90.01
91.00	09100	EMERGENCY	0.509506	0	3,021,097	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.181597	0	301,402	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	18,531,824	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	18,531,824	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:56 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	259,053	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,777	0		54.00
60.00	06000	LABORATORY	783,758	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,463	0		63.00
65.00	06500	RESPIRATORY THERAPY	240,728	0		65.00
66.00	06600	PHYSICAL THERAPY	195,977	0		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	236,408	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	92,963	0		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	113,815	0		67.01
68.00	06800	SPEECH PATHOLOGY	124,652	0		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	102,713	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	175,644	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,711	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	785,941	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
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
90.00	09000	CLINIC	316,690	0		90.00
90.01	09001	WOUND CARE	1,809	0		90.01
91.00	09100	EMERGENCY	1,539,267	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	356,136	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	5,933,505	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,933,505	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,496	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)	894	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	287	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	140	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)	528	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)	287	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,205,490	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)	35,062	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)	706,352	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,499,138	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)	3,499,138	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,338.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,234,987	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)	1,234,987	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	494,930	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,729,917	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)	671,290	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	671,290	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)	602	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,339.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,408,078	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	343,661	4,205,490	0.081717	1,408,078	115,064	90.00
91.00	Nursing Program cost	0	4,205,490	0.000000	1,408,078	0	91.00
92.00	Allied health cost	0	4,205,490	0.000000	1,408,078	0	92.00
93.00	All other Medical Education	0	4,205,490	0.000000	1,408,078	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 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)	1,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,496	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)	894	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	140	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)	8	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	4,205,490	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)	4,205,490	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)	4,205,490	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,811.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	22,489	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)	22,489	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 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)						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	0	0	0.00	0	0	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)	132,779	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)	155,268	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)	602	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,811.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,692,318	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:56 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	343,661	4,205,490	0.081717	1,692,318	138,291	90.00
91.00	Nursing Program cost	0	4,205,490	0.000000	1,692,318	0	91.00
92.00	Allied health cost	0	4,205,490	0.000000	1,692,318	0	92.00
93.00	All other Medical Education	0	4,205,490	0.000000	1,692,318	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		796,508		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.645516	51,728	33,391	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166524	143,585	23,910	54.00
60.00	06000	LABORATORY	0.248249	607,653	150,849	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.244726	21,362	5,228	63.00
65.00	06500	RESPIRATORY THERAPY	0.506736	116,449	59,009	65.00
66.00	06600	PHYSICAL THERAPY	0.463974	47,847	22,200	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.600663	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.464693	52,349	24,326	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.896811	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.750093	6,426	4,820	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.605518	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.253935	147,665	37,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.145604	45,836	6,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166909	460,696	76,894	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
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
90.00	09000	CLINIC	0.514629	15,272	7,859	90.00
90.01	09001	WOUND CARE	0.263205	0	0	90.01
91.00	09100	EMERGENCY	0.509506	76,536	38,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.181597	2,773	3,277	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,796,177	494,930	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,796,177		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z324 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.645516	5,878	3,794	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166524	9,954	1,658	54.00
60.00	06000	LABORATORY	0.248249	56,470	14,019	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.244726	4,677	1,145	63.00
65.00	06500	RESPIRATORY THERAPY	0.506736	26,780	13,570	65.00
66.00	06600	PHYSICAL THERAPY	0.463974	54,956	25,498	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.600663	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.464693	58,725	27,289	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.896811	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.750093	5,400	4,051	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.605518	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.253935	22,873	5,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.145604	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166909	105,157	17,552	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
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
90.00	09000	CLINIC	0.514629	0	0	90.00
90.01	09001	WOUND CARE	0.263205	0	0	90.01
91.00	09100	EMERGENCY	0.509506	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.181597	95	112	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		350,965	114,496	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)		350,965		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:56 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		109,312		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.645516	434	280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166524	55,908	9,310	54.00
60.00	06000	LABORATORY	0.248249	75,340	18,703	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.244726	2,664	652	63.00
65.00	06500	RESPIRATORY THERAPY	0.506736	41,570	21,065	65.00
66.00	06600	PHYSICAL THERAPY	0.463974	5,094	2,363	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.600663	92	55	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.464693	6,174	2,869	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.896811	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.750093	267	200	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.605518	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.253935	26,460	6,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.145604	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166909	99,421	16,594	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
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	3.536055	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.484722	0	0	88.01
90.00	09000	CLINIC	0.514629	4,665	2,401	90.00
90.01	09001	WOUND CARE	0.263205	0	0	90.01
91.00	09100	EMERGENCY	0.509506	42,790	21,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.181597	25,191	29,766	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		386,070	132,779	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)		386,070		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,891,893	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,891,893	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	8,980,812	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	78,294	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,818,486	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,084,032	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)	3,084,032	30.00
31.00	Primary payer payments	1,448	31.00
32.00	Subtotal (line 30 minus line 31)	3,082,584	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)	755,328	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	490,963	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	540,505	36.00
37.00	Subtotal (see instructions)	3,573,547	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,573,547	40.00
40.01	Sequestration adjustment (see instructions)	71,471	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,525,786	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)	-23,710	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: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:56 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,103,695		3,525,786	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)		1,103,695		3,525,786	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		386,272		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		23,710	6.02
7.00	Total Medicare program liability (see instructions)		1,489,967		3,502,076	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: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		548,584		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/26/2023	35,700		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)		35,700		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)		584,284		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		186,627		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		770,911		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: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 8:56 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 8:56 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	678,003	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	115,641	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	287	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	793,644	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	793,644	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	793,644	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,000	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	786,644	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	786,644	0	19.00
19.01	Sequestration adjustment (see instructions)	15,733	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	584,284	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	186,627	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 8:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,729,917	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,729,917	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,747,216	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,747,216	19.00
20.00	Deductibles (exclude professional component)	233,556	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,513,660	22.00
23.00	Coinsurance	400	23.00
24.00	Subtotal (line 22 minus line 23)	1,513,260	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,946	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,115	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,794	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,520,375	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,520,375	30.00
30.01	Sequestration adjustment (see instructions)	30,408	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,103,695	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	386,272	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 8:56 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	155,268		1.00
2.00	Medical and other services		5,933,505	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	155,268	5,933,505	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)	155,268	5,933,505	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	386,070	18,531,824	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)	386,070	18,531,824	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)	386,070	18,531,824	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	230,802	12,598,319	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)	155,268	5,933,505	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)	155,268	5,933,505	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)	155,268	5,933,505	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)	155,268	5,933,505	36.00
37.00	ADJUST SETTLEMENT TO ZERO	-136,581	-6,095,481	37.00
38.00	Subtotal (line 36 ± line 37)	18,687	-161,976	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)	18,687	-161,976	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	18,687	-161,976	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 8:56 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	1,100	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	4,655,932	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	837,288	0	0	0	7.00
8.00	Prepaid expenses	190,738	0	0	0	8.00
9.00	Other current assets	452,659	0	0	0	9.00
10.00	Due from other funds	83,413	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,221,130	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,791	0	0	0	12.00
13.00	Land improvements	509,926	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,089,230	0	0	0	15.00
16.00	Accumulated depreciation	-15,514,593	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	8,011,668	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,772,022	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	99,821	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	99,821	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,092,973	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,321,132	0	0	0	37.00
38.00	Salaries, wages, and fees payable	697,082	0	0	0	38.00
39.00	Payroll taxes payable	429,932	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,369,422	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,817,568	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	45,241,377	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	45,241,377	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,058,945	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-30,965,972				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)	-30,965,972	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,092,973	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 8:56 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		-31,141,086		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		175,115				2.00
3.00	Total (sum of line 1 and line 2)		-30,965,971		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)		-30,965,971		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-30,965,973		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	ROUNDING		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: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 8:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,983,287		1,983,287	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,983,287		1,983,287	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,983,287		1,983,287	17.00
18.00	Ancillary services	4,066,473	102,043,752	106,110,225	18.00
19.00	Outpatient services	0	175,489	175,489	19.00
20.00	RURAL HEALTH CLINIC	0	293,978	293,978	20.00
20.01	RURAL HEALTH CLINIC II	0	5,883,942	5,883,942	20.01
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
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,049,760	108,397,161	114,446,921	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,757,990		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,757,990		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/29/2024 8:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	114,446,921	1.00
2.00	Less contractual allowances and discounts on patients' accounts	76,953,893	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,493,028	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,757,990	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-264,962	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	440,117	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	440,117	25.00
26.00	Total (line 5 plus line 25)	175,155	26.00
27.00	NON OPERATING REVENUE	40	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	40	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	175,115	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:56 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	3,148	0	3,148	0	3,148	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	113,001	0	113,001	0	113,001	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	35,520	0	35,520	0	35,520	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	31,170	0	31,170	0	31,170	9.00
10.00	Subtotal (sum of lines 1 through 9)	182,839	0	182,839	0	182,839	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	293	293	0	293	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	293	293	0	293	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	182,839	293	183,132	0	183,132	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	16,859	16,859	0	16,859	29.00
30.00	Administrative Costs	30,609	5,508	36,117	0	36,117	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,609	22,367	52,976	0	52,976	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	213,448	22,660	236,108	0	236,108	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:56 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	3,148		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	113,001		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	35,520		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	31,170		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	182,839		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	293		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	293		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	183,132		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	16,859		29.00
30.00	Administrative Costs	0	36,117		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	52,976		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	236,108		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:56 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	3,351	0	3,351	0	3,351	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	149,982	0	149,982	0	149,982	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	49,717	0	49,717	0	49,717	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	40,464	0	40,464	0	40,464	9.00
10.00	Subtotal (sum of lines 1 through 9)	243,514	0	243,514	0	243,514	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	243,514	0	243,514	0	243,514	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	33,368	23,443	56,811	-16,215	40,596	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,368	23,443	56,811	-16,215	40,596	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	276,882	23,443	300,325	-16,215	284,110	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:56 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	3,351		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	149,982		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	49,717		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	40,464		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	243,514		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	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	243,514		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	0		29.00
30.00	Administrative Costs	0	40,596		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	40,596		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	284,110		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:56 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.85	769	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.85	769		1	769	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)	0.85	769			769	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)	183,132	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)	183,132	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)	52,976	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	301,825	15.00
16.00	Total overhead (sum of lines 14 and 15)	354,801	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	354,801	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	354,801	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	537,933	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:56 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	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.09	1,697	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.09	1,697		1	1,697	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)	1.09	1,697			1,697	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)					243,514	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)					243,514	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)					40,596	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					390,271	15.00
16.00	Total overhead (sum of lines 14 and 15)					430,867	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					430,867	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					430,867	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					674,381	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:56 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)		537,933	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		10,810	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		527,123	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		769	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)		769	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		685.47	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	303.29	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	303.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	254	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	77,036	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	77,036	16.00
16.01	Total program charges (see instructions)(from contractor's records)		33,202	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,316	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,935	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.)		37,973	16.04
16.05	Total program cost (see instructions)	0	61,908	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,635	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,450	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		61,908	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,440	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)		66,348	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)		66,348	26.00
26.01	Sequestration adjustment (see instructions)		1,327	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		59,009	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)		6,012	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: 15-1324 Component CCN: 15-8502	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:56 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)		674,381	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		8,233	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		666,148	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,697	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,697	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		392.54	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	229.47	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	229.47	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	504	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	115,653	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	115,653	16.00
16.01	Total program charges (see instructions)(from contractor's records)		64,734	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,784	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,693	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.)		71,889	16.04
16.05	Total program cost (see instructions)	0	87,582	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,099	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,170	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		87,582	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,721	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)		89,303	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)		89,303	26.00
26.01	Sequestration adjustment (see instructions)		1,786	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		84,870	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)		2,647	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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:56 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)	182,839	182,839	182,839	182,839	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000130	0.000130	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	24	24	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	584	3,048	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	608	3,072	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	183,132	183,132	183,132	183,132	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	354,801	354,801	354,801	354,801	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003320	0.016775	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,178	5,952	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,786	9,024	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	17	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	893.00	530.82	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	5	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,786	2,654	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		10,810	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)		4,440	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:56 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)	243,514	243,514	243,514	243,514	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000140	0.000140	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	34	34	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	533	2,372	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	567	2,406	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	243,514	243,514	243,514	243,514	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	430,867	430,867	430,867	430,867	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002328	0.009880	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,003	4,257	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,570	6,663	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	54	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	196.25	123.39	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	6	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)	981	740	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)		8,233	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)		1,721	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:56 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		59,009	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)		59,009	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		6,012	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		65,021	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:56 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		84,870	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)		84,870	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		2,647	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		87,517	7.00

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