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: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/28/2024 4:36 pm

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report   Date: Time:
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 GREENE COUNTY GENERAL HOSPITAL (15-1317) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	799,269	-666,274	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	86,372	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-10,422		0	10.00
10.01	RURAL HEALTH CLINIC II	0		68,861		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-129,838		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-606		0	10.03
200.00	TOTAL	0	885,641	-738,279	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: R.R 1	PO Box: 1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	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	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MY LINTON CLINIC	158535	99915		12/18/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MY BLOOMFIELD CLINIC	158533	99915		12/18/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MY WESTGATE CLINIC	158534	99915		12/18/2018	N	N	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	MY WORTHINGTON CLINIC	158538	99915		12/12/2018	N	N	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 4:36 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 4:36 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 4:36 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 4:36 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	Y		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	444,996	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 4:36 pm

		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: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 4:36 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/14/2024	Y	05/14/2024	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 4:36 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.383.4182	KERRY.BEJARANO@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 4:36 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	N	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	N	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
	STATE MEDICAID FORMS			
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

	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	20	7,300	36,360.00	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)		20	7,300	36,360.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	3,000.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	39,360.00	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

	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)	808	31	1,515			1.00
2.00	HMO and other (see instructions)	103	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	286	0	335			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,094	31	1,850			7.00
8.00	INTENSIVE CARE UNIT	38	4	125			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	146			13.00
14.00	Total (see instructions)	1,132	48	2,121	0.00	332.26	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,800	0	29,392	0.00	40.39	26.00
26.01	RURAL HEALTH CLINIC II	1,671	0	9,001	0.00	10.20	26.01
26.02	RURAL HEALTH CLINIC III	1,974	0	7,994	0.00	9.92	26.02
26.03	RURAL HEALTH CLINIC IV	3,349	0	9,914	0.00	8.63	26.03
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	401.40	27.00
28.00	Observation Bed Days		133	1,359			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	24	54			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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2024 4:36 pm

	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	291	14	638	1.00
2.00	HMO and other (see instructions)			26	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	291	14	638	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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: 15-1317 Component CCN: 15-8535	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC I	

		1.00	
	Clinic Address and Identification		
1.00	Street	1210 N. 1000 W.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LINTON	IN	47441	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						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: 15-1317 Component CCN: 15-8535	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC I	

			County				
			4.00				
2.00	City, State, ZIP Code, County		GREENE				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						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-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC II

		1.00	
	Clinic Address and Identification		
1.00	Street	55 N. JUDGE ST.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BLOOMFIELD	IN	47424	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						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: 15-1317 Component CCN: 15-8533	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC II	

			County			
			4.00			
2.00	City, State, ZIP Code, County		GREENE			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						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-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC III

		1.00	
	Clinic Address and Identification		
1.00	Street	1985 E. FREEDOM DR.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NEWBERRY	IN	47449	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8

Component CCN: 15-8534 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC III

		County		
		4.00		
2.00	City, State, ZIP Code, County	GREENE		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						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-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC IV	

			1.00	
	Clinic Address and Identification			
1.00	Street		102 E. MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WORTHINGTON	IN	47471	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						11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC IV	

			County				
			4.00				
2.00	City, State, ZIP Code, County		GREENE				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						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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II | Date/Time Prepared: 5/28/2024 4:36 pm

		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)	0.315676	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,021,105	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,198,096	5.00
6.00	Medicaid charges	35,866,470	6.00
7.00	Medicaid cost (line 1 times line 6)	11,322,184	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	7,102,983	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)	7,102,983	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)	276,265	0	276,265	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	87,210	0	87,210	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)	87,210	0	87,210	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	5,815,113	26.00
27.00	Medicare reimbursable bad debts (see instructions)	333,635	27.00
27.01	Medicare allowable bad debts (see instructions)	513,285	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,301,828	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,853,310	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,940,520	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,043,503	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 8:17 pm

		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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 4:36 pm

		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		3,020,360	3,020,360	69,224	3,089,584	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		719,957	719,957	0	719,957	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,145,632	6,145,632	92,282	6,237,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,926,293	6,157,932	9,084,225	-161,506	8,922,719	5.00
7.00	00700	OPERATION OF PLANT	876,578	1,249,771	2,126,349	0	2,126,349	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	242,400	242,400	8.00
9.00	00900	HOUSEKEEPING	450,524	387,027	837,551	-242,400	595,151	9.00
10.00	01000	DIETARY	706,589	415,466	1,122,055	-935,009	187,046	10.00
11.00	01100	CAFETERIA	0	0	0	935,009	935,009	11.00
13.00	01300	NURSING ADMINISTRATION	626,453	168,365	794,818	0	794,818	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-28,070	-28,070	0	-28,070	14.00
15.00	01500	PHARMACY	706,024	124,871	830,895	0	830,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,635	44,743	369,378	0	369,378	16.00
17.00	01700	SOCIAL SERVICE	248,341	1,825	250,166	0	250,166	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,045,631	1,045,631	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,486,469	1,145,038	4,631,507	603,689	5,235,196	30.00
31.00	03100	INTENSIVE CARE UNIT	520,937	205,398	726,335	0	726,335	31.00
43.00	04300	NURSERY	870	106	976	190,522	191,498	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	813,518	786,495	1,600,013	0	1,600,013	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	271,038	13	271,051	-268,616	2,435	52.00
53.00	05300	ANESTHESIOLOGY	0	1,057,023	1,057,023	-1,045,631	11,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,189,817	693,695	1,883,512	0	1,883,512	54.00
60.00	06000	LABORATORY	1,127,140	2,775,625	3,902,765	0	3,902,765	60.00
65.00	06500	RESPIRATORY THERAPY	811,223	106,423	917,646	-2,539	915,107	65.00
66.00	06600	PHYSICAL THERAPY	599,160	18,837	617,997	0	617,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	256,103	0	256,103	0	256,103	67.00
68.00	06800	SPEECH PATHOLOGY	58,727	0	58,727	0	58,727	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,128,135	3,128,135	-2,475,828	652,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,475,828	2,475,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	278,581	2,764,511	3,043,092	0	3,043,092	73.00
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	3,392,236	956,509	4,348,745	-76,804	4,271,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	940,751	351,443	1,292,194	40,648	1,332,842	88.01
88.02	08802	RURAL HEALTH CLINIC III	766,651	338,254	1,104,905	21,654	1,126,559	88.02
88.03	08803	RURAL HEALTH CLINIC IV	735,778	310,235	1,046,013	14,502	1,060,515	88.03
91.00	09100	EMERGENCY	2,473,757	1,478,725	3,952,482	2,539	3,955,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,588,193	34,524,344	59,112,537	525,595	59,638,132	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	2,953,657	531,007	3,484,664	-525,595	2,959,069	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	27,541,850	35,055,351	62,597,201	0	62,597,201	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 4:36 pm

		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	-22,365	3,067,219	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	719,957	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,237,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,229,588	5,693,131	5.00
7.00	00700	OPERATION OF PLANT	-5,685	2,120,664	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	242,400	8.00
9.00	00900	HOUSEKEEPING	0	595,151	9.00
10.00	01000	DIETARY	0	187,046	10.00
11.00	01100	CAFETERIA	-255,445	679,564	11.00
13.00	01300	NURSING ADMINISTRATION	0	794,818	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-28,070	14.00
15.00	01500	PHARMACY	0	830,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,738	364,640	16.00
17.00	01700	SOCIAL SERVICE	0	250,166	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,045,631	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-540,732	4,694,464	30.00
31.00	03100	INTENSIVE CARE UNIT	0	726,335	31.00
43.00	04300	NURSERY	0	191,498	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,600,013	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,435	52.00
53.00	05300	ANESTHESIOLOGY	0	11,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,883,512	54.00
60.00	06000	LABORATORY	0	3,902,765	60.00
65.00	06500	RESPIRATORY THERAPY	-7,200	907,907	65.00
66.00	06600	PHYSICAL THERAPY	0	617,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	256,103	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,727	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-71,302	581,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,475,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-504,396	2,538,696	73.00
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	0	4,271,941	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,332,842	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,126,559	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,060,515	88.03
91.00	09100	EMERGENCY	-880,697	3,074,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,567,779	53,070,353	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-40,214	2,918,855	192.00
194.00	07950	FOUNDATION / MOBS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,607,993	55,989,208	200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet Non-CMS W | Date/Time Prepared: 5/28/2024 4:36 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	07700		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	07800		78.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
88.02	RURAL HEALTH CLINIC III	08802		88.02
88.03	RURAL HEALTH CLINIC IV	08803		88.03
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
102.00	OPIOID TREATMENT PROGRAM	10200		102.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
194.00	FOUNDATION / MOBS	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 4:36 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,045,631	1.00
	TOTALS		0	1,045,631	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	268,616	0	1.00
	TOTALS		268,616	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	588,801	346,208	1.00
	TOTALS		588,801	346,208	
	D - RHC ALLOCATION				
1.00	RURAL HEALTH CLINIC II	88.01	40,648	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	21,654	0	2.00
3.00	RURAL HEALTH CLINIC IV	88.03	14,502	0	3.00
	TOTALS		76,804	0	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,224	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	92,282	2.00
	TOTALS		0	161,506	
	F - LAUNDRY AND HOUSEKEEPING RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	242,400	1.00
	TOTALS		0	242,400	
	G - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,475,828	1.00
	TOTALS		0	2,475,828	
	I - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	525,595	0	1.00
	TOTALS		525,595	0	
	J - NURSERY RECLASS				
1.00	NURSERY	43.00	190,522	0	1.00
	TOTALS		190,522	0	
	K - EKG RECLASSIFICATION				
1.00	EMERGENCY	91.00	0	2,539	1.00
	TOTALS		0	2,539	
500.00	Grand Total: Increases		1,650,338	4,274,112	500.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 4:36 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CRNA RECLASS					
1.00	ANESTHESIOLOGY	53.00	0	1,045,631	0	1.00
	TOTALS		0	1,045,631		
	B - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	268,616	0	0	1.00
	TOTALS		268,616	0		
	C - DIETARY RECLASS					
1.00	DIETARY	10.00	588,801	346,208	0	1.00
	TOTALS		588,801	346,208		
	D - RHC ALLOCATION					
1.00	RURAL HEALTH CLINIC	88.00	76,804	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		76,804	0		
	E - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	161,506	12	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	161,506		
	F - LAUNDRY AND HOUSEKEEPING RECLASS					
1.00	HOUSEKEEPING	9.00	0	242,400	0	1.00
	TOTALS		0	242,400		
	G - IMPLANTABLE DEVICES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,475,828	0	1.00
	TOTALS		0	2,475,828		
	I - HOSPITALIST RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	525,595	0	0	1.00
	TOTALS		525,595	0		
	J - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	190,522	0	0	1.00
	TOTALS		190,522	0		
	K - EKG RECLASSIFICATION					
1.00	RESPIRATORY THERAPY	65.00	0	2,539	0	1.00
	TOTALS		0	2,539		
500.00	Grand Total: Decreases		1,650,338	4,274,112		500.00

RECLASSIFICATIONS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 Non-CMS Worksheet | Date/Time Prepared: 5/28/2024 4:36 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,045,631	ANESTHESIOLOGY	53.00	0	1,045,631	1.00
	TOTALS		0	1,045,631	TOTALS		0	1,045,631	
	B - LABOR & DELIVERY								
1.00	ADULTS & PEDIATRICS	30.00	268,616	0	DELIVERY ROOM & LABOR ROOM	52.00	268,616	0	1.00
	TOTALS		268,616	0	TOTALS		268,616	0	
	C - DIETARY RECLASS								
1.00	CAFETERIA	11.00	588,801	346,208	DIETARY	10.00	588,801	346,208	1.00
	TOTALS		588,801	346,208	TOTALS		588,801	346,208	
	D - RHC ALLOCATION								
1.00	RURAL HEALTH CLINIC II	88.01	40,648	0	RURAL HEALTH CLINIC	88.00	76,804	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	21,654	0		0.00	0	0	2.00
3.00	RURAL HEALTH CLINIC IV	88.03	14,502	0		0.00	0	0	3.00
	TOTALS		76,804	0	TOTALS		76,804	0	
	E - INSURANCE RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,224	ADMINISTRATIVE & GENERAL	5.00	0	161,506	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	92,282		0.00	0	0	2.00
	TOTALS		0	161,506	TOTALS		0	161,506	
	F - LAUNDRY AND HOUSEKEEPING RECLASS								
1.00	LAUNDRY & LINEN SERVICE	8.00	0	242,400	HOUSEKEEPING	9.00	0	242,400	1.00
	TOTALS		0	242,400	TOTALS		0	242,400	
	G - IMPLANTABLE DEVICES RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,475,828	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,475,828	1.00
	TOTALS		0	2,475,828	TOTALS		0	2,475,828	
	I - HOSPITALIST RECLASS								
1.00	ADULTS & PEDIATRICS	30.00	525,595	0	PHYSICIANS PRIVATE OFFICES	192.00	525,595	0	1.00
	TOTALS		525,595	0	TOTALS		525,595	0	
	J - NURSERY RECLASS								
1.00	NURSERY	43.00	190,522	0	ADULTS & PEDIATRICS	30.00	190,522	0	1.00
	TOTALS		190,522	0	TOTALS		190,522	0	
	K - EKG RECLASSIFICATION								
1.00	EMERGENCY	91.00	0	2,539	RESPIRATORY THERAPY	65.00	0	2,539	1.00
	TOTALS		0	2,539	TOTALS		0	2,539	
500.00	Grand Total: Increases		1,650,338	4,274,112	Grand Total: Decreases		1,650,338	4,274,112	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

		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	624,598	0	0	0	3,400	1.00
2.00	Land Improvements	3,485,761	0	0	0	20,151	2.00
3.00	Buildings and Fixtures	11,060,650	0	0	0	151,810	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,119,511	0	0	0	429,148	5.00
6.00	Movable Equipment	4,560,920	690,202	0	690,202	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,851,440	690,202	0	690,202	604,509	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,851,440	690,202	0	690,202	604,509	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	621,198	0	1.00
2.00	Land Improvements	3,465,610	0	2.00
3.00	Buildings and Fixtures	10,908,840	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,690,363	0	5.00
6.00	Movable Equipment	5,251,122	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,937,133	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,937,133	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2024 4:36 pm

	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	999,079	1,428,902	592,379	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	719,957	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,719,036	1,428,902	592,379	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,020,360	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	719,957	2.00
3.00	Total (sum of lines 1-2)	0	3,740,317	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2024 4:36 pm

	Cost Center Description	COMPUTATION OF RATIOS Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL 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	19,686,011	0	19,686,011	0.789426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,251,122	0	5,251,122	0.210574	0	2.00
3.00	Total (sum of lines 1-2)	24,937,133	0	24,937,133	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL 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	976,714	1,428,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	719,957	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,696,671	1,428,902	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	592,379	69,224	0	0	3,067,219	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	719,957	2.00
3.00	Total (sum of lines 1-2)	592,379	69,224	0	0	3,787,176	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 4:36 pm

	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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,685	OPERATION OF PLANT	7.00	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	-1,428,629			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-224,029	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	-4,738	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-11,291	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 4:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CPR TRAINING	B	440	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC. REVENUE - ADMIN	B	-386,811	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	AHA DUES	A	-3,279	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-1,641	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-179,013	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-32,589	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.07	340B EXPENSE	A	-504,396	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	CRNA ADJUSTMENT TO MARKET	A	-1,045,631	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.10	ORTHO CLINIC - START-UP COSTS	A	-40,214	PHYSICIANS PRIVATE OFFICES	192.00	0	33.10
33.11	HOSPITAL ASSESSMENT FEE	A	-2,659,040	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	BOND AMORTIZATION EXPENSE	A	10,224	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	MISC. EXPENSE - ADMIN	A	-244	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.16	REBATES	B	-71,302	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.16
33.17	CATERING REVENUE	B	-20,125	CAFETERIA	11.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,607,993				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2024 4:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	594,212	540,732	53,480	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	7,200	7,200	0	0	0	2.00
3.00	91.00	EMERGENCY	1,143,762	880,697	263,065	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,745,174	1,428,629	316,545		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	540,732	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	7,200	2.00
3.00	91.00	EMERGENCY	0	0	0	880,697	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,428,629	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,067,219	3,067,219				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	719,957		719,957			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,237,914	0	0	6,237,914		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,693,131	267,607	51,334	662,773	6,674,845	5.00
7.00	00700	OPERATION OF PLANT	2,120,664	394,058	75,591	198,535	2,788,848	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	242,400	20,978	4,024	0	267,402	8.00
9.00	00900	HOUSEKEEPING	595,151	20,937	4,016	102,039	722,143	9.00
10.00	01000	DIETARY	187,046	113,365	21,747	26,678	348,836	10.00
11.00	01100	CAFETERIA	679,564	111,662	21,420	133,357	946,003	11.00
13.00	01300	NURSING ADMINISTRATION	794,818	22,308	4,279	141,885	963,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-28,070	142,070	27,253	0	141,253	14.00
15.00	01500	PHARMACY	830,895	53,339	10,232	159,907	1,054,373	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	364,640	44,283	8,495	73,526	490,944	16.00
17.00	01700	SOCIAL SERVICE	250,166	11,839	2,271	56,247	320,523	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,694,464	704,328	135,108	926,362	6,460,262	30.00
31.00	03100	INTENSIVE CARE UNIT	726,335	111,330	21,356	117,987	977,008	31.00
43.00	04300	NURSERY	191,498	15,744	3,020	43,348	253,610	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,600,013	203,717	39,079	184,253	2,027,062	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,435	8,557	1,642	549	13,183	52.00
53.00	05300	ANESTHESIOLOGY	11,392	0	0	0	11,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,883,512	189,178	36,290	269,480	2,378,460	54.00
60.00	06000	LABORATORY	3,902,765	108,463	20,806	255,285	4,287,319	60.00
65.00	06500	RESPIRATORY THERAPY	907,907	4,860	932	183,733	1,097,432	65.00
66.00	06600	PHYSICAL THERAPY	617,997	37,511	7,196	135,703	798,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	256,103	37,511	7,196	58,005	358,815	67.00
68.00	06800	SPEECH PATHOLOGY	58,727	20,106	3,857	13,301	95,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	581,005	0	0	0	581,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,475,828	0	0	0	2,475,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,538,696	34,811	6,678	63,096	2,643,281	73.00
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	4,271,941	0	48,155	750,909	5,071,005	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,332,842	0	28,640	222,276	1,583,758	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,126,559	0	24,161	178,542	1,329,262	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,060,515	0	30,624	169,930	1,261,069	88.03
91.00	09100	EMERGENCY	3,074,324	235,870	45,246	560,279	3,915,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,070,353	2,914,432	690,648	5,687,985	52,338,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,548	2,215	0	13,763	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,918,855	141,239	27,094	549,929	3,637,117	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	55,989,208	3,067,219	719,957	6,237,914	55,989,208	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 4:36 pm

		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	6,674,845					5.00
7.00	00700	OPERATION OF PLANT	377,479	3,166,327				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,194	21,486	325,082			8.00
9.00	00900	HOUSEKEEPING	97,744	21,444	0	841,331		9.00
10.00	01000	DIETARY	47,216	116,110	0	2,296	514,458	10.00
11.00	01100	CAFETERIA	128,044	114,366	0	383	0	11.00
13.00	01300	NURSING ADMINISTRATION	130,384	22,848	0	765	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,119	145,510	0	383	0	14.00
15.00	01500	PHARMACY	142,713	54,630	0	9,758	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,451	45,355	0	1,435	0	16.00
17.00	01700	SOCIAL SERVICE	43,384	12,126	0	383	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	874,412	721,377	78,924	281,750	360,107	30.00
31.00	03100	INTENSIVE CARE UNIT	132,241	114,025	24,614	78,355	154,351	31.00
43.00	04300	NURSERY	34,327	16,125	0	9,376	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	274,369	208,649	21,105	107,439	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,784	8,765	0	13,011	0	52.00
53.00	05300	ANESTHESIOLOGY	1,542	0	0	3,444	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,932	193,758	51,953	35,207	0	54.00
60.00	06000	LABORATORY	580,301	111,089	0	34,920	0	60.00
65.00	06500	RESPIRATORY THERAPY	148,541	4,978	0	16,838	0	65.00
66.00	06600	PHYSICAL THERAPY	108,067	38,420	65,025	52,906	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,567	38,420	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,993	20,593	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,641	0	0	383	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	335,111	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357,776	35,654	0	0	0	73.00
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	686,376	257,110	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	214,366	152,913	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	179,920	129,002	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	170,689	163,507	0	0	0	88.03
91.00	09100	EMERGENCY	530,004	241,580	83,461	161,206	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,180,687	3,009,840	325,082	810,238	514,458	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,863	11,828	0	3,635	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	492,295	144,659	0	27,458	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,674,845	3,166,327	325,082	841,331	514,458	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/28/2024 4:36 pm

		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	1,188,796					11.00
13.00	01300	NURSING ADMINISTRATION	42,661	1,159,948				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	306,265			14.00
15.00	01500	PHARMACY	49,174	0	472	1,311,120		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,986	0	176	0	647,347	16.00
17.00	01700	SOCIAL SERVICE	18,182	0	67	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	305,028	629,196	7,255	0	111,986	30.00
31.00	03100	INTENSIVE CARE UNIT	37,016	76,334	928	0	6,169	31.00
43.00	04300	NURSERY	12,212	0	2	0	2,221	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,918	177,190	1,960	0	68,010	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	6,169	52.00
53.00	05300	ANESTHESIOLOGY	0	0	207	0	740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,011	0	1,553	0	36,149	54.00
60.00	06000	LABORATORY	139,651	0	87,681	0	84,513	60.00
65.00	06500	RESPIRATORY THERAPY	64,045	0	4,361	0	12,338	65.00
66.00	06600	PHYSICAL THERAPY	50,802	0	528	0	20,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,980	0	0	0	6,539	67.00
68.00	06800	SPEECH PATHOLOGY	4,342	0	0	0	1,974	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	38,470	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	146,015	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,967	0	182	1,311,120	0	73.00
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	6,307	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	6,307	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	6,307	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	6,307	88.03
91.00	09100	EMERGENCY	134,386	277,228	2,565	0	249,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,148,361	1,159,948	292,422	1,311,120	632,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	15,052	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	40,435	0	13,843	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,188,796	1,159,948	306,265	1,311,120	647,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	394,665					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	258,876	0	10,089,173	0	10,089,173	30.00
31.00	03100	INTENSIVE CARE UNIT	53,204	0	1,654,245	0	1,654,245	31.00
43.00	04300	NURSERY	11,911	0	339,784	0	339,784	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,971,702	0	2,971,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,970	0	46,882	0	46,882	52.00
53.00	05300	ANESTHESIOLOGY	0	0	17,325	0	17,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,141,023	0	3,141,023	54.00
60.00	06000	LABORATORY	0	0	5,325,474	0	5,325,474	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,348,533	0	1,348,533	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,135,129	0	1,135,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	467,321	0	467,321	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	135,893	0	135,893	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	698,499	0	698,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,956,954	0	2,956,954	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,372,980	0	4,372,980	73.00
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	6,020,798	0	6,020,798	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,957,344	0	1,957,344	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,644,491	0	1,644,491	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,601,572	0	1,601,572	88.03
91.00	09100	EMERGENCY	66,704	0	5,662,138	0	5,662,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	394,665	0	51,587,260	0	51,587,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	46,141	0	46,141	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	4,355,807	0	4,355,807	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	394,665	0	55,989,208	0	55,989,208	202.00

COST ALLOCATION STATISTICS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet Non-CMS W | Date/Time Prepared: 5/28/2024 4:36 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	2	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	4	HOURS OF SERVICE	9.00
10.00	DIETARY	5	MEALS SERVED	10.00
11.00	CAFETERIA	6	HOURS	11.00
13.00	NURSING ADMINISTRATION	7	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	8	COSTED REQUIS.	14.00
15.00	PHARMACY	9	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	10	TIME SPENT	16.00
17.00	SOCIAL SERVICE	11	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	12	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	267,607	51,334	318,941	0	5.00
7.00	00700	OPERATION OF PLANT	0	394,058	75,591	469,649	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,978	4,024	25,002	0	8.00
9.00	00900	HOUSEKEEPING	0	20,937	4,016	24,953	0	9.00
10.00	01000	DIETARY	0	113,365	21,747	135,112	0	10.00
11.00	01100	CAFETERIA	0	111,662	21,420	133,082	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,308	4,279	26,587	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,070	27,253	169,323	0	14.00
15.00	01500	PHARMACY	0	53,339	10,232	63,571	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,283	8,495	52,778	0	16.00
17.00	01700	SOCIAL SERVICE	0	11,839	2,271	14,110	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	704,328	135,108	839,436	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,330	21,356	132,686	0	31.00
43.00	04300	NURSERY	0	15,744	3,020	18,764	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	203,717	39,079	242,796	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,557	1,642	10,199	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	189,178	36,290	225,468	0	54.00
60.00	06000	LABORATORY	0	108,463	20,806	129,269	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,860	932	5,792	0	65.00
66.00	06600	PHYSICAL THERAPY	0	37,511	7,196	44,707	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,511	7,196	44,707	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,106	3,857	23,963	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,811	6,678	41,489	0	73.00
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	48,155	48,155	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	28,640	28,640	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	24,161	24,161	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	30,624	30,624	0	88.03
91.00	09100	EMERGENCY	0	235,870	45,246	281,116	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,914,432	690,648	3,605,080	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,548	2,215	13,763	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	141,239	27,094	168,333	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,067,219	719,957	3,787,176	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 4:36 pm

		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	318,941					5.00
7.00	00700	OPERATION OF PLANT	18,038	487,687				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,730	3,309	30,041			8.00
9.00	00900	HOUSEKEEPING	4,671	3,303	0	32,927		9.00
10.00	01000	DIETARY	2,256	17,884	0	90	155,342	10.00
11.00	01100	CAFETERIA	6,119	17,615	0	15	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,231	3,519	0	30	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	914	22,412	0	15	0	14.00
15.00	01500	PHARMACY	6,820	8,414	0	382	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	6,986	0	56	0	16.00
17.00	01700	SOCIAL SERVICE	2,073	1,868	0	15	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,759	111,106	7,293	11,025	108,735	30.00
31.00	03100	INTENSIVE CARE UNIT	6,319	17,562	2,275	3,067	46,607	31.00
43.00	04300	NURSERY	1,640	2,484	0	367	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,111	32,137	1,950	4,205	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85	1,350	0	509	0	52.00
53.00	05300	ANESTHESIOLOGY	74	0	0	135	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,384	29,843	4,801	1,378	0	54.00
60.00	06000	LABORATORY	27,730	17,110	0	1,367	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,098	767	0	659	0	65.00
66.00	06600	PHYSICAL THERAPY	5,164	5,918	6,009	2,071	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,321	5,918	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	621	3,172	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,758	0	0	15	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,014	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,097	5,492	0	0	0	73.00
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	32,799	39,601	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,244	23,552	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,598	19,869	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	8,157	25,184	0	0	0	88.03
91.00	09100	EMERGENCY	25,327	37,209	7,713	6,309	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	295,327	463,584	30,041	31,710	155,342	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	89	1,822	0	142	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	23,525	22,281	0	1,075	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	318,941	487,687	30,041	32,927	155,342	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 4:36 pm

		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	156,831					11.00
13.00	01300	NURSING ADMINISTRATION	5,628	41,995				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	176,488			14.00
15.00	01500	PHARMACY	6,487	0	272	85,946		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,671	0	102	0	68,768	16.00
17.00	01700	SOCIAL SERVICE	2,399	0	39	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,241	22,779	4,181	0	11,896	30.00
31.00	03100	INTENSIVE CARE UNIT	4,883	2,764	535	0	655	31.00
43.00	04300	NURSERY	1,611	0	1	0	236	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,335	6,415	1,130	0	7,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	655	52.00
53.00	05300	ANESTHESIOLOGY	0	0	119	0	79	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,096	0	895	0	3,840	54.00
60.00	06000	LABORATORY	18,423	0	50,527	0	8,978	60.00
65.00	06500	RESPIRATORY THERAPY	8,449	0	2,513	0	1,311	65.00
66.00	06600	PHYSICAL THERAPY	6,702	0	304	0	2,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,976	0	0	0	695	67.00
68.00	06800	SPEECH PATHOLOGY	573	0	0	0	210	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22,169	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	84,141	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,294	0	105	85,946	0	73.00
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	670	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	670	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	670	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	670	88.03
91.00	09100	EMERGENCY	17,729	10,037	1,478	0	26,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,497	41,995	168,511	85,946	67,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	1,599	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,334	0	7,977	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	16,176	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	156,831	41,995	192,664	85,946	68,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	20,504					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,450		1,211,901	0	1,211,901	30.00
31.00	03100	INTENSIVE CARE UNIT	2,764		220,117	0	220,117	31.00
43.00	04300	NURSERY	619		25,722	0	25,722	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0		320,304	0	320,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206		13,004	0	13,004	52.00
53.00	05300	ANESTHESIOLOGY	0		407	0	407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		297,705	0	297,705	54.00
60.00	06000	LABORATORY	0		253,404	0	253,404	60.00
65.00	06500	RESPIRATORY THERAPY	0		26,589	0	26,589	65.00
66.00	06600	PHYSICAL THERAPY	0		73,103	0	73,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		55,617	0	55,617	67.00
68.00	06800	SPEECH PATHOLOGY	0		28,539	0	28,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		25,942	0	25,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		100,155	0	100,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		153,423	0	153,423	73.00
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		121,225	0	121,225	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		63,106	0	63,106	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		53,298	0	53,298	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		64,635	0	64,635	88.03
91.00	09100	EMERGENCY	3,465		416,864	0	416,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,504	0	3,525,060	0	3,525,060	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		17,415	0	17,415	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		228,525	0	228,525	192.00
194.00	07950	FOUNDATION / MOBS	0		0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	16,176	0	16,176	201.00
202.00		TOTAL (sum lines 118 through 201)	20,504	0	3,787,176	0	3,787,176	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 4:36 pm

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	73,836					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		90,348				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	27,541,850			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,442	6,442	2,926,293	-6,674,845	49,314,363	5.00
7.00	00700	OPERATION OF PLANT	9,486	9,486	876,578	0	2,788,848	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	505	0	0	267,402	8.00
9.00	00900	HOUSEKEEPING	504	504	450,524	0	722,143	9.00
10.00	01000	DIETARY	2,729	2,729	117,788	0	348,836	10.00
11.00	01100	CAFETERIA	2,688	2,688	588,801	0	946,003	11.00
13.00	01300	NURSING ADMINISTRATION	537	537	626,453	0	963,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	3,420	0	0	141,253	14.00
15.00	01500	PHARMACY	1,284	1,284	706,024	0	1,054,373	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	324,635	0	490,944	16.00
17.00	01700	SOCIAL SERVICE	285	285	248,341	0	320,523	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	16,955	4,090,158	0	6,460,262	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	520,937	0	977,008	31.00
43.00	04300	NURSERY	379	379	191,392	0	253,610	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	4,904	813,518	0	2,027,062	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	206	2,422	0	13,183	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	11,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	1,189,817	0	2,378,460	54.00
60.00	06000	LABORATORY	2,611	2,611	1,127,140	0	4,287,319	60.00
65.00	06500	RESPIRATORY THERAPY	117	117	811,223	0	1,097,432	65.00
66.00	06600	PHYSICAL THERAPY	903	903	599,160	0	798,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	903	256,103	0	358,815	67.00
68.00	06800	SPEECH PATHOLOGY	484	484	58,727	0	95,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	581,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,475,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838	838	278,581	0	2,643,281	73.00
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	6,043	3,315,432	0	5,071,005	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,594	981,399	0	1,583,758	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,032	788,305	0	1,329,262	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,843	750,280	0	1,261,069	88.03
91.00	09100	EMERGENCY	5,678	5,678	2,473,757	0	3,915,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,158	86,670	25,113,788	-6,674,845	45,663,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	278	278	0	0	13,763	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,400	3,400	2,428,062	0	3,637,117	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,067,219	719,957	6,237,914		6,674,845	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.540969	7.968710	0.226489		0.135353	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		318,941	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.006468	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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			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	74,420					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	29,096				8.00
9.00	00900	HOUSEKEEPING	504	0	219,850			9.00
10.00	01000	DIETARY	2,729	0	600	11,489		10.00
11.00	01100	CAFETERIA	2,688	0	100	0	21,903	11.00
13.00	01300	NURSING ADMINISTRATION	537	0	200	0	786	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	0	100	0	0	14.00
15.00	01500	PHARMACY	1,284	0	2,550	0	906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	375	0	792	16.00
17.00	01700	SOCIAL SERVICE	285	0	100	0	335	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	7,064	73,625	8,042	5,620	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,203	20,475	3,447	682	31.00
43.00	04300	NURSERY	379	0	2,450	0	225	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	1,889	28,075	0	1,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	0	3,400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	900	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,650	9,200	0	2,248	54.00
60.00	06000	LABORATORY	2,611	0	9,125	0	2,573	60.00
65.00	06500	RESPIRATORY THERAPY	117	0	4,400	0	1,180	65.00
66.00	06600	PHYSICAL THERAPY	903	5,820	13,825	0	936	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	0	0	0	276	67.00
68.00	06800	SPEECH PATHOLOGY	484	0	0	0	80	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	100	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	838	0	0	0	460	73.00
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	6,043	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,594	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,032	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,843	0	0	0	0	88.03
91.00	09100	EMERGENCY	5,678	7,470	42,125	0	2,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,742	29,096	211,725	11,489	21,158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	278	0	950	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,400	0	7,175	0	745	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,166,327	325,082	841,331	514,458	1,188,796	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.546721	11.172739	3.826841	44.778310	54.275487	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	487,687	30,041	32,927	155,342	156,831	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.553171	1.032479	0.149770	13.520933	7.160252	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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	215,506					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,193,050				14.00
15.00	01500	PHARMACY	0	8,000	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,992	0	131,173		16.00
17.00	01700	SOCIAL SERVICE	0	1,137	0	0	497	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,898	123,022	0	22,692	326	30.00
31.00	03100	INTENSIVE CARE UNIT	14,182	15,730	0	1,250	67	31.00
43.00	04300	NURSERY	0	35	0	450	15	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,920	33,237	0	13,781	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,250	5	52.00
53.00	05300	ANESTHESIOLOGY	0	3,502	0	150	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,341	0	7,325	0	54.00
60.00	06000	LABORATORY	0	1,486,731	0	17,125	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,943	0	2,500	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,948	0	4,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,325	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	400	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	652,307	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,475,828	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,092	100	0	0	73.00
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	1,278	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,278	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,278	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,278	0	88.03
91.00	09100	EMERGENCY	51,506	43,488	0	50,513	84	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	215,506	4,958,333	100	128,123	497	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	3,050	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	234,717	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,159,948	306,265	1,311,120	647,347	394,665	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.382439	0.058976	13,111.200000	4.935063	794.094567	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,995	192,664	85,946	68,768	20,504	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.194867	0.033985	859.460000	0.524254	41.255533	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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 4:36 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		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
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	88.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,089,173		10,089,173	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,654,245		1,654,245	0	0	31.00
43.00	04300	NURSERY	339,784		339,784	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,971,702		2,971,702	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,882		46,882	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,325		17,325	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,141,023		3,141,023	0	0	54.00
60.00	06000	LABORATORY	5,325,474		5,325,474	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,348,533	0	1,348,533	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,135,129	0	1,135,129	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	467,321	0	467,321	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	135,893	0	135,893	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	698,499		698,499	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,956,954		2,956,954	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,372,980		4,372,980	0	0	73.00
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	6,020,798		6,020,798	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,957,344		1,957,344	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,644,491		1,644,491	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,601,572		1,601,572	0	0	88.03
91.00	09100	EMERGENCY	5,662,138		5,662,138	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,272,723		4,272,723		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	55,859,983	0	55,859,983	0	0	200.00
201.00		Less Observation Beds	4,272,723		4,272,723		0	201.00
202.00		Total (see instructions)	51,587,260	0	51,587,260	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,999,091		2,999,091			30.00
31.00	03100	INTENSIVE CARE UNIT	366,947		366,947			31.00
43.00	04300	NURSERY	254,716		254,716			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,516,050	8,732,592	10,248,642	0.289961	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,340	11,057	228,397	0.205265	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	281,397	792,326	1,073,723	0.016135	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	645,625	33,840,067	34,485,692	0.091082	0.000000	54.00
60.00	06000	LABORATORY	1,117,194	27,886,710	29,003,904	0.183612	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,172,578	4,004,559	5,177,137	0.260479	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	351,492	4,124,564	4,476,056	0.253600	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,710	1,454,451	1,623,161	0.287908	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,971	305,496	355,467	0.382294	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,213,968	4,390,867	5,604,835	0.124624	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	763,487	1,968,073	2,731,560	1.082515	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,411,734	16,755,650	19,167,384	0.228147	0.000000	73.00
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	7,210,480	7,210,480			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,395,276	2,395,276			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,916,385	1,916,385			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,262,939	1,262,939			88.03
91.00	09100	EMERGENCY	773,789	29,507,821	30,281,610	0.186983	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	296,155	2,259,076	2,555,231	1.672147	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	14,600,244	148,818,389	163,418,633			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,600,244	148,818,389	163,418,633			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 4:36 pm

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	10,089,173		10,089,173	0	10,089,173	30.00
31.00	03100	INTENSIVE CARE UNIT	1,654,245		1,654,245	0	1,654,245	31.00
43.00	04300	NURSERY	339,784		339,784	0	339,784	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,971,702		2,971,702	0	2,971,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,882		46,882	0	46,882	52.00
53.00	05300	ANESTHESIOLOGY	17,325		17,325	0	17,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,141,023		3,141,023	0	3,141,023	54.00
60.00	06000	LABORATORY	5,325,474		5,325,474	0	5,325,474	60.00
65.00	06500	RESPIRATORY THERAPY	1,348,533	0	1,348,533	0	1,348,533	65.00
66.00	06600	PHYSICAL THERAPY	1,135,129	0	1,135,129	0	1,135,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	467,321	0	467,321	0	467,321	67.00
68.00	06800	SPEECH PATHOLOGY	135,893	0	135,893	0	135,893	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	698,499		698,499	0	698,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,956,954		2,956,954	0	2,956,954	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,372,980		4,372,980	0	4,372,980	73.00
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	6,020,798		6,020,798	0	6,020,798	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,957,344		1,957,344	0	1,957,344	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,644,491		1,644,491	0	1,644,491	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,601,572		1,601,572	0	1,601,572	88.03
91.00	09100	EMERGENCY	5,662,138		5,662,138	0	5,662,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,272,723		4,272,723		4,272,723	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	55,859,983	0	55,859,983	0	55,859,983	200.00
201.00		Less Observation Beds	4,272,723		4,272,723		4,272,723	201.00
202.00		Total (see instructions)	51,587,260	0	51,587,260	0	51,587,260	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 4:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,999,091		2,999,091			30.00
31.00	03100	INTENSIVE CARE UNIT	366,947		366,947			31.00
43.00	04300	NURSERY	254,716		254,716			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,516,050	8,732,592	10,248,642	0.289961	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,340	11,057	228,397	0.205265	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	281,397	792,326	1,073,723	0.016135	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	645,625	33,840,067	34,485,692	0.091082	0.000000	54.00
60.00	06000	LABORATORY	1,117,194	27,886,710	29,003,904	0.183612	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,172,578	4,004,559	5,177,137	0.260479	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	351,492	4,124,564	4,476,056	0.253600	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,710	1,454,451	1,623,161	0.287908	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,971	305,496	355,467	0.382294	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,213,968	4,390,867	5,604,835	0.124624	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	763,487	1,968,073	2,731,560	1.082515	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,411,734	16,755,650	19,167,384	0.228147	0.000000	73.00
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	7,210,480	7,210,480	0.835007	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,395,276	2,395,276	0.817168	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,916,385	1,916,385	0.858121	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,262,939	1,262,939	1.268131	0.000000	88.03
91.00	09100	EMERGENCY	773,789	29,507,821	30,281,610	0.186983	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	296,155	2,259,076	2,555,231	1.672147	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	14,600,244	148,818,389	163,418,633			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,600,244	148,818,389	163,418,633			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 4:36 pm
	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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/28/2024 4:36 pm

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	320,304	10,248,642	0.031253	472,696	14,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,004	228,397	0.056936	0	0	52.00
53.00	05300	ANESTHESIOLOGY	407	1,073,723	0.000379	79,985	30	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,705	34,485,692	0.008633	340,408	2,939	54.00
60.00	06000	LABORATORY	253,404	29,003,904	0.008737	519,576	4,540	60.00
65.00	06500	RESPIRATORY THERAPY	26,589	5,177,137	0.005136	458,678	2,356	65.00
66.00	06600	PHYSICAL THERAPY	73,103	4,476,056	0.016332	131,740	2,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,617	1,623,161	0.034265	25,216	864	67.00
68.00	06800	SPEECH PATHOLOGY	28,539	355,467	0.080286	15,730	1,263	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,942	5,604,835	0.004629	495,668	2,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,155	2,731,560	0.036666	568,949	20,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,423	19,167,384	0.008004	1,023,847	8,195	73.00
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	121,225	7,210,480	0.016812	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	63,106	2,395,276	0.026346	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	53,298	1,916,385	0.027812	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	64,635	1,262,939	0.051178	0	0	88.03
91.00	09100	EMERGENCY	416,864	30,281,610	0.013766	81,683	1,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	513,235	2,555,231	0.200857	878	176	92.00
200.00		Total (lines 50 through 199)	2,580,555	159,797,879		4,215,054	61,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/28/2024 4:36 pm

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	10,248,642	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	228,397	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,073,723	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,485,692	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	29,003,904	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,177,137	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,476,056	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,623,161	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	355,467	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,604,835	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,731,560	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,167,384	0.000000	73.00
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	7,210,480	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,395,276	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,916,385	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,262,939	0.000000	88.03
91.00	09100	EMERGENCY	0	0	0	30,281,610	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,555,231	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	159,797,879		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317

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

Worksheet D Part IV

Date/Time Prepared: 5/28/2024 4:36 pm

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	472,696	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	79,985	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	340,408	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	519,576	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	458,678	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	131,740	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	25,216	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,730	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	495,668	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	568,949	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,023,847	0	0	0	73.00
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
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
91.00	09100	EMERGENCY	0.000000	81,683	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	878	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,215,054	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
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	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 4:36 pm

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	0.289961	0	1,541,405	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205265	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016135	0	65,213	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091082	0	8,868,961	0	0	54.00
60.00	06000	LABORATORY	0.183612	0	6,818,268	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260479	0	1,019,927	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.253600	0	1,493,440	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.287908	0	416,681	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.382294	0	29,556	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124624	0	808,851	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082515	0	663,525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228147	0	6,437,243	305	0	73.00
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
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.186983	0	6,392,116	88	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.672147	0	569,083	0	0	92.00
200.00		Subtotal (see instructions)		0	35,124,269	393	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	35,124,269	393	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	446,947	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,052	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,803	0	54.00
60.00	06000	LABORATORY	1,251,916	0	60.00
65.00	06500	RESPIRATORY THERAPY	265,670	0	65.00
66.00	06600	PHYSICAL THERAPY	378,736	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,966	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,299	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100,802	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	718,276	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,468,638	70	73.00
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
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
91.00	09100	EMERGENCY	1,195,217	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	951,590	0	92.00
200.00		Subtotal (see instructions)	7,717,912	86	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,717,912	86	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 4:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289961	0	964,991	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205265	0	3,686	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016135	0	8,947	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091082	0	2,924,944	0	0	54.00
60.00	06000	LABORATORY	0.183612	0	3,582,330	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260479	0	363,344	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.253600	0	190,941	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.287908	0	106,022	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.382294	0	186,885	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124624	0	230,787	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082515	0	81,673	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228147	0	1,550,532	0	0	73.00
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
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.186983	0	4,308,918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.672147	0	165,670	0	0	92.00
200.00		Subtotal (see instructions)		0	14,669,670	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	14,669,670	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/28/2024 4:36 pm
	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	279,810	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	757	0	52.00
53.00	05300	ANESTHESIOLOGY	144	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,410	0	54.00
60.00	06000	LABORATORY	657,759	0	60.00
65.00	06500	RESPIRATORY THERAPY	94,643	0	65.00
66.00	06600	PHYSICAL THERAPY	48,423	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,525	0	67.00
68.00	06800	SPEECH PATHOLOGY	71,445	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,762	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,412	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	353,749	0	73.00
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
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
91.00	09100	EMERGENCY	805,694	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	277,025	0	92.00
200.00		Subtotal (see instructions)	3,003,558	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,003,558	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 4:36 pm

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)	3,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,874	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,515	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	335	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	808	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)	286	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)	10,089,173	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)	1,053,247	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,035,926	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,035,926	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)	3,144.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,540,368	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,540,368	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,654,245	125	13,233.96	38	502,890	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,358,914	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)	4,402,172	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)	899,190	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	899,190	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,144.02	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,272,723	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,211,901	10,089,173	0.120119	4,272,723	513,235	90.00
91.00	Nursing Program cost	0	10,089,173	0.000000	4,272,723	0	91.00
92.00	Allied health cost	0	10,089,173	0.000000	4,272,723	0	92.00
93.00	All other Medical Education	0	10,089,173	0.000000	4,272,723	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,874	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,515	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	335	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	31	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)	146	15.00
16.00	Nursery days (title V or XIX only)	13	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)	10,089,173	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)	1,053,247	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,035,926	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,035,926	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)	3,144.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	97,465	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)	97,465	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 4:36 pm

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)	339,784	146	2,327.29	13	30,255	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,654,245	125	13,233.96	4	52,936	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	279,725	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)	460,381	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,144.02	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,272,723	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,211,901	10,089,173	0.120119	4,272,723	513,235	90.00
91.00	Nursing Program cost	0	10,089,173	0.000000	4,272,723	0	91.00
92.00	Allied health cost	0	10,089,173	0.000000	4,272,723	0	92.00
93.00	All other Medical Education	0	10,089,173	0.000000	4,272,723	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,336,334		30.00
31.00	03100	INTENSIVE CARE UNIT		104,842		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289961	472,696	137,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205265	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016135	79,985	1,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091082	340,408	31,005	54.00
60.00	06000	LABORATORY	0.183612	519,576	95,400	60.00
65.00	06500	RESPIRATORY THERAPY	0.260479	458,678	119,476	65.00
66.00	06600	PHYSICAL THERAPY	0.253600	131,740	33,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.287908	25,216	7,260	67.00
68.00	06800	SPEECH PATHOLOGY	0.382294	15,730	6,013	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124624	495,668	61,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082515	568,949	615,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228147	1,023,847	233,588	73.00
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
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.186983	81,683	15,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.672147	878	1,468	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,215,054	1,358,914	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)		4,215,054		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289961	1,734	503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205265	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016135	299	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091082	17,647	1,607	54.00
60.00	06000	LABORATORY	0.183612	40,752	7,483	60.00
65.00	06500	RESPIRATORY THERAPY	0.260479	86,760	22,599	65.00
66.00	06600	PHYSICAL THERAPY	0.253600	119,579	30,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.287908	116,308	33,486	67.00
68.00	06800	SPEECH PATHOLOGY	0.382294	19,345	7,395	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124624	41,977	5,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082515	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228147	89,057	20,318	73.00
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
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.186983	4	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.672147	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		533,462	128,953	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		533,462		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 4:36 pm
	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		193,315		30.00
31.00	03100	INTENSIVE CARE UNIT		27,590		31.00
43.00	04300	NURSERY		160,438		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289961	39,382	11,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205265	66,340	13,617	52.00
53.00	05300	ANESTHESIOLOGY	0.016135	2,814	45	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091082	24,909	2,269	54.00
60.00	06000	LABORATORY	0.183612	107,605	19,758	60.00
65.00	06500	RESPIRATORY THERAPY	0.260479	78,534	20,456	65.00
66.00	06600	PHYSICAL THERAPY	0.253600	5,126	1,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.287908	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.382294	380	145	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124624	58,893	7,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082515	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228147	122,034	27,842	73.00
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	0.835007	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.817168	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.858121	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.268131	0	0	88.03
91.00	09100	EMERGENCY	0.186983	164,023	30,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.672147	86,634	144,865	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		756,674	279,725	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)		756,674		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,717,998	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)	7,717,998	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)	7,795,178	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)	49,073	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,667,058	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)	2,079,047	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)	2,079,047	30.00
31.00	Primary payer payments	1,567	31.00
32.00	Subtotal (line 30 minus line 31)	2,077,480	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)	478,691	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	311,149	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	326,159	36.00
37.00	Subtotal (see instructions)	2,388,629	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)	2,388,629	40.00
40.01	Sequestration adjustment (see instructions)	47,773	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	3,007,130	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)	-666,274	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: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	Hospital	Cost

Line	Description		
		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00
		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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,911,457		3,007,130	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	326,800		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)		326,800		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,238,257		3,007,130	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		799,269		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		666,274	6.02
7.00	Total Medicare program liability (see instructions)		4,037,526		2,340,856	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: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2024 4:36 pm

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		804,272		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	122,700		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)		122,700		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)		926,972		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		86,372		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,013,344		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: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/28/2024 4:36 pm
	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
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/28/2024 4:36 pm

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)	908,182	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)	130,243	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	286	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,038,425	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,038,425	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,038,425	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,400	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,034,025	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,034,025	0	19.00
19.01	Sequestration adjustment (see instructions)	20,681	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	926,972	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)	86,372	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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part V Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,402,172	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)	4,402,172	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,446,194	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)	4,446,194	19.00
20.00	Deductibles (exclude professional component)	348,756	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,097,438	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,097,438	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34,594	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,486	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,312	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,119,924	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)	4,119,924	30.00
30.01	Sequestration adjustment (see instructions)	82,398	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,238,257	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)	799,269	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: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/28/2024 4:36 pm

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	460,381		1.00
2.00	Medical and other services		3,003,558	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	460,381	3,003,558	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)	460,381	3,003,558	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	756,674	14,669,670	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)	756,674	14,669,670	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)	756,674	14,669,670	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	296,293	11,666,112	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)	460,381	3,003,558	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)	460,381	3,003,558	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)	460,381	3,003,558	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)	460,381	3,003,558	36.00
37.00	ZERO OUT MEDICAID	-460,381	-3,003,558	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Prepared: 5/28/2024 4:36 pm

		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	843,780	0	0	0	1.00
2.00	Temporary investments	1,849,016	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,540,601	0	0	0	4.00
5.00	Other receivable	2,852,749	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	529,859	0	0	0	7.00
8.00	Prepaid expenses	327,489	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,943,494	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	923,204	0	0	0	12.00
13.00	Land improvements	3,465,610	0	0	0	13.00
14.00	Accumulated depreciation	-282,452	0	0	0	14.00
15.00	Buildings	11,681,329	0	0	0	15.00
16.00	Accumulated depreciation	-2,414,956	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	7,776,249	0	0	0	19.00
20.00	Accumulated depreciation	-2,795,984	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	5,251,122	0	0	0	23.00
24.00	Accumulated depreciation	-1,564,259	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)	22,039,863	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,262,605	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	2,825,170	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,087,775	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,071,132	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,707,097	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,073,696	0	0	0	38.00
39.00	Payroll taxes payable	717,186	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,048,652	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	1,022,600	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,569,231	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,210,053	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,210,053	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,779,284	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,291,848				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)	12,291,848	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,071,132	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/28/2024 4:36 pm

		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		13,967,886		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,676,038				2.00
3.00	Total (sum of line 1 and line 2)		12,291,848		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)		12,291,848		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,291,848		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2024 4:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,577,028		4,577,028	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)	4,577,028		4,577,028	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	366,947		366,947	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	366,947		366,947	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,943,975		4,943,975	17.00
18.00	Ancillary services	9,916,495	111,636,063	121,552,558	18.00
19.00	Outpatient services	840,551	32,577,267	33,417,818	19.00
20.00	RURAL HEALTH CLINIC	0	7,210,480	7,210,480	20.00
20.01	RURAL HEALTH CLINIC II	0	2,395,276	2,395,276	20.01
20.02	RURAL HEALTH CLINIC III	0	1,916,385	1,916,385	20.02
20.03	RURAL HEALTH CLINIC IV	0	1,262,939	1,262,939	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS	0	6,356,027	6,356,027	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,701,021	163,354,437	179,055,458	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,597,201		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)		62,597,201		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1317	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/28/2024 4:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	179,055,458	1.00
2.00	Less contractual allowances and discounts on patients' accounts	121,373,868	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,681,590	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,597,201	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,915,611	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 REVENUES	3,239,573	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,239,573	25.00
26.00	Total (line 5 plus line 25)	-1,676,038	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,676,038	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,184,465	0	1,184,465	0	1,184,465	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	851,755	0	851,755	0	851,755	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	515,668	0	515,668	0	515,668	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	18,259	0	18,259	0	18,259	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,570,147	0	2,570,147	0	2,570,147	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	520,375	520,375	0	520,375	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	520,375	520,375	0	520,375	14.00
15.00	Medical Supplies	0	220,662	220,662	0	220,662	15.00
16.00	Transportation (Health Care Staff)	0	22,546	22,546	0	22,546	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	243,208	243,208	0	243,208	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,570,147	763,583	3,333,730	0	3,333,730	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	136,784	136,784	0	136,784	29.00
30.00	Administrative Costs	822,089	56,142	878,231	0	878,231	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	822,089	192,926	1,015,015	0	1,015,015	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,392,236	956,509	4,348,745	0	4,348,745	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-16,597	1,167,868	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	61,595	913,350	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	515,668	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	-121,802	-103,543	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-76,804	2,493,343	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	520,375	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	520,375	14.00
15.00	Medical Supplies	0	220,662	15.00
16.00	Transportation (Health Care Staff)	0	22,546	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	243,208	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-76,804	3,256,926	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	136,784	29.00
30.00	Administrative Costs	0	878,231	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,015,015	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-76,804	4,271,941	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC II

		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	320,330	0	320,330	0	320,330	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	218,938	0	218,938	0	218,938	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	291,501	0	291,501	0	291,501	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	70,806	0	70,806	0	70,806	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	901,575	0	901,575	0	901,575	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	192,277	192,277	0	192,277	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	192,277	192,277	0	192,277	14.00
15.00	Medical Supplies	0	107,294	107,294	0	107,294	15.00
16.00	Transportation (Health Care Staff)	0	1,422	1,422	0	1,422	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	108,716	108,716	0	108,716	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	901,575	300,993	1,202,568	0	1,202,568	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	40,750	40,750	0	40,750	29.00
30.00	Administrative Costs	39,176	9,700	48,876	0	48,876	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	39,176	50,450	89,626	0	89,626	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	940,751	351,443	1,292,194	0	1,292,194	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-7,910	312,420	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-22,248	196,690	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	291,501	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	70,806	141,612	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	40,648	942,223	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	192,277	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	192,277	14.00
15.00	Medical Supplies	0	107,294	15.00
16.00	Transportation (Health Care Staff)	0	1,422	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	108,716	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	40,648	1,243,216	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	40,750	29.00
30.00	Administrative Costs	0	48,876	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	89,626	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	40,648	1,332,842	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1
Component CCN: 15-8534 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC III

		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	329,091	0	329,091	0	329,091	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	165,996	0	165,996	0	165,996	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	153,346	0	153,346	0	153,346	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	24,105	0	24,105	0	24,105	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	672,538	0	672,538	0	672,538	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	195,653	195,653	0	195,653	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	195,653	195,653	0	195,653	14.00
15.00	Medical Supplies	0	75,015	75,015	0	75,015	15.00
16.00	Transportation (Health Care Staff)	0	3,335	3,335	0	3,335	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	78,350	78,350	0	78,350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	672,538	274,003	946,541	0	946,541	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	53,686	53,686	0	53,686	29.00
30.00	Administrative Costs	94,114	10,565	104,679	0	104,679	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	94,114	64,251	158,365	0	158,365	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	766,652	338,254	1,104,906	0	1,104,906	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	24,505	353,596	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-26,957	139,039	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	153,346	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	24,105	48,210	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	21,653	694,191	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	195,653	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	195,653	14.00
15.00	Medical Supplies	0	75,015	15.00
16.00	Transportation (Health Care Staff)	0	3,335	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	78,350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	21,653	968,194	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	53,686	29.00
30.00	Administrative Costs	0	104,679	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	158,365	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	21,653	1,126,559	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8538 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC IV

		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	221,656	0	221,656	0	221,656	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	268,003	0	268,003	0	268,003	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	110,905	0	110,905	0	110,905	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	26,891	0	26,891	0	26,891	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	627,455	0	627,455	0	627,455	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	166,756	166,756	0	166,756	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	166,756	166,756	0	166,756	14.00
15.00	Medical Supplies	0	41,506	41,506	0	41,506	15.00
16.00	Transportation (Health Care Staff)	0	36,939	36,939	0	36,939	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	78,445	78,445	0	78,445	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	627,455	245,201	872,656	0	872,656	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	47,557	47,557	0	47,557	29.00
30.00	Administrative Costs	108,323	17,477	125,800	0	125,800	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	108,323	65,034	173,357	0	173,357	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	735,778	310,235	1,046,013	0	1,046,013	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC IV

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	221,656	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-12,388	255,615	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	110,905	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	26,890	53,781	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	14,502	641,957	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	166,756	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	166,756	14.00
15.00	Medical Supplies	0	41,506	15.00
16.00	Transportation (Health Care Staff)	0	36,939	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	78,445	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	14,502	887,158	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	47,557	29.00
30.00	Administrative Costs	0	125,800	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	173,357	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	14,502	1,060,515	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC I

		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	3.09	7,126	1	3		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	5.63	22,266	2,100	11,823		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.72	29,392		11,826	29,392	4.00
5.00	Visiting Nurse	8.40	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.68	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)	17.80	29,392			29,392	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	3,256,926	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)	3,256,926	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)	1,015,015	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,748,857	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,763,872	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,763,872	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,763,872	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	6,020,798	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC II

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.05	3,833	1	1		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.52	5,168	2,100	3,192		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.57	9,001		3,193	9,001	4.00
5.00	Visiting Nurse	4.28	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.50	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.35	9,001			9,001	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,243,216	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,243,216	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)	89,626	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	624,502	15.00
16.00	Total overhead (sum of lines 14 and 15)	714,128	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	714,128	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	714,128	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,957,344	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8534	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC III	

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.09	4,814	4,200	4,578		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.22	3,180	2,100	2,562		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.31	7,994		7,140	7,994	4.00
5.00	Visiting Nurse	2.89	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.20	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)	5.40	7,994			7,994	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)	968,194	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)	968,194	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)	158,365	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	517,932	15.00
16.00	Total overhead (sum of lines 14 and 15)	676,297	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	676,297	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	676,297	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,644,491	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC IV

		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	0.81	5,966	4,200	3,402		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.81	3,948	2,100	3,801		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.62	9,914		7,203	9,914	4.00
5.00	Visiting Nurse	2.19	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.38	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)	5.19	9,914			9,914	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)	887,158	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)	887,158	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)	173,357	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	541,057	15.00
16.00	Total overhead (sum of lines 14 and 15)	714,414	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	714,414	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	714,414	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,601,572	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	RHC I	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	6,020,798	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	404,616	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	5,616,182	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	29,392	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)	29,392	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	191.08	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	229.01	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	191.08	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,746	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	715,786	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	54	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	10,318	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	10,318	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	726,104	16.00
16.01	Total program charges (see instructions)(from contractor's records)		771,851	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		33,570	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,580	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.)		486,633	16.04
16.05	Total program cost (see instructions)	0	518,213	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		86,233	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		130,284	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		518,213	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		91,023	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)		609,236	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)		609,236	26.00
26.01	Sequestration adjustment (see instructions)		12,185	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		607,473	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-10,422	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: 15-1317 Component CCN: 15-8533	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	RHC II	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,957,344	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		309,667	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,647,677	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,001	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,001	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		183.05	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	192.04	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	183.05	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,633	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	298,921	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	38	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	6,956	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	6,956	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	305,877	16.00
16.01	Total program charges (see instructions)(from contractor's records)		366,468	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,004	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,681	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.)		203,230	16.04
16.05	Total program cost (see instructions)	0	209,911	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		45,159	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		62,611	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		209,911	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		77,449	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		287,360	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)		287,360	26.00
26.01	Sequestration adjustment (see instructions)		5,747	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		212,752	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)		68,861	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: 15-1317 Component CCN: 15-8534	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	RHC III	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,644,491	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		108,870	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,535,621	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,994	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,994	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		192.10	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	315.03	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	192.10	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,969	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	378,245	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	5	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	961	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	961	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	379,206	16.00
16.01	Total program charges (see instructions)(from contractor's records)		421,104	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,166	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,756	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		258,470	16.04
16.05	Total program cost (see instructions)	0	271,226	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		43,362	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		72,710	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		271,226	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,937	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)		300,163	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)		300,163	26.00
26.01	Sequestration adjustment (see instructions)		6,003	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		423,998	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)		-129,838	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: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-3 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | RHC IV

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,601,572	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		117,432	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,484,140	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,914	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,914	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		149.70	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	169.42	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	149.70	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,339	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	499,848	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	10	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,497	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,497	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	501,345	16.00
16.01	Total program charges (see instructions)(from contractor's records)		540,086	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,971	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,471	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.)		352,750	16.04
16.05	Total program cost (see instructions)	0	359,221	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		53,936	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		95,778	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		359,221	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		50,421	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)		409,642	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)		409,642	26.00
26.01	Sequestration adjustment (see instructions)		8,193	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		402,055	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)		-606	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: 15-1317 Component CCN: 15-8535	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	RHC I	

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,493,343	2,493,343	2,493,343	2,493,343	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001090	0.004615	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,718	11,507	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	106,536	98,115	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	109,254	109,622	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,256,926	3,256,926	3,256,926	3,256,926	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,763,872	2,763,872	2,763,872	2,763,872	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.033545	0.033658	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	92,714	93,026	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	201,968	202,648	0	0	10.00
11.00	Total number of injections/infusions (from your records)	494	2,092	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	408.84	96.87	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	889	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,906	86,117	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)		404,616	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)		91,023	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | RHC II

		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)	942,223	942,223	942,223	942,223	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003741	0.018619	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,525	17,543	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	82,575	93,043	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	86,100	110,586	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,243,216	1,243,216	1,243,216	1,243,216	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	714,128	714,128	714,128	714,128	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.069256	0.088952	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	49,458	63,523	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	135,558	174,109	0	0	10.00
11.00	Total number of injections/infusions (from your records)	392	1,951	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	345.81	89.24	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	25	771	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8,645	68,804	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)		309,667	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)		77,449	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | RHC III

		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)	694,191	694,191	694,191	694,191	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001409	0.006067	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	978	4,212	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	28,630	30,277	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	29,608	34,489	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	968,194	968,194	968,194	968,194	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	676,297	676,297	676,297	676,297	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.030581	0.035622	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20,682	24,091	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	50,290	58,580	0	0	10.00
11.00	Total number of injections/infusions (from your records)	140	603	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	359.21	97.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	17	235	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,107	22,830	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)		108,870	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)		28,937	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/28/2024 4:36 pm

Title XVIII | RHC IV

		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)	641,957	641,957	641,957	641,957	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000268	0.011404	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	172	7,321	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,753	52,803	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,925	60,124	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	887,158	887,158	887,158	887,158	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	714,414	714,414	714,414	714,414	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005551	0.067771	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,966	48,417	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,891	108,541	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	1,062	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	355.64	102.20	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	469	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)	2,489	47,932	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)		117,432	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)		50,421	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		607,473	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)		607,473	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,422	6.02
7.00	Total Medicare program liability (see instructions)		597,051	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: 15-1317 Component CCN: 15-8533	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		212,752	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)		212,752	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		68,861	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		281,613	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: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/28/2024 4:36 pm

RHC III

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		423,998	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)		423,998	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		129,838	6.02
7.00	Total Medicare program liability (see instructions)		294,160	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: 15-1317 Component CCN: 15-8538	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm
		RHC IV	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		402,055	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)		402,055	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		606	6.02
7.00	Total Medicare program liability (see instructions)		401,449	7.00

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