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: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 7:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 7:24 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (15-1329) 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	Craig Gilliland		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Craig Gilliland			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-413,074	-1,125,772	0	-54,956	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	8,096	0		92,687	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-41,595		0	10.00
10.01	MEDICAL ARTS CENTER II	0		10,138		0	10.01
200.00	TOTAL	0	-404,978	-1,157,229	0	37,731	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	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	MARGARET MARY COMMUNITY HOSPITAL	15Z329	99915		09/10/2020	N	O	O	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	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MEDICAL ARTS CENTER	158567	99915		06/04/2022	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 7:24 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 7:24 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	520,026	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:24 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 7:24 am

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

		Y/N	Date	
		1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

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

Financial Data and Reports

		Y/N	Type	Date	
		1.00	2.00	3.00	
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

Approved Educational Activities

		Y/N	Legal Oper.	
		1.00	2.00	
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

Bad Debts

		Y/N	
		1.00	
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

PS&R Data

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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	03/20/2024	Y	03/20/2024	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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 7:24 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 7:24 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 7:24 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	74,664.00	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)		18	6,570	74,664.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	5,688.00	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	80,352.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	MEDICAL ARTS CENTER	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 7:24 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,193	83	3,111			1.00
2.00	HMO and other (see instructions)	642	575				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	325	0	325			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	277			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,518	83	3,713			7.00
8.00	INTENSIVE CARE UNIT	65	6	237			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		0	672			13.00
14.00	Total (see instructions)	1,583	89	4,622	0.00	495.26	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,552	3,726	11,706	0.00	15.43	26.00
26.01	MEDICAL ARTS CENTER	5,786	2,184	17,262	0.00	24.33	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	535.02	27.00
28.00	Observation Bed Days		1,923	2,238			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 7:24 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	376	29	1,222	1.00
2.00	HMO and other (see instructions)			148	270		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	376	29	1,222	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	MEDICAL ARTS CENTER	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:24 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	112 N. BUCKEYE ST.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD	IN	47037	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:24 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:24 am

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			188 STATE ROUTE 129		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BATESVILLE		IN	47006	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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: 15-1329
Component CCN: 15-8567

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

Worksheet S-8

Date/Time Prepared:
5/29/2024 7:24 am

RHC II

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		RIPLEY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/29/2024 7:24 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	9,727	95	664	10,486	11.00
12.00	Hospice Inpatient Respite Care	0	0	1	1	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	9,727	95	665	10,487	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 7:24 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.286018	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,123,558	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	33,862,721	6.00
7.00	Medicaid cost (line 1 times line 6)	9,685,348	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,561,790	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)	2,561,790	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)	250,539	843,530	1,094,069	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	71,659	843,530	915,189	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)	71,659	843,530	915,189	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	9,103,366	26.00
27.00	Medicare reimbursable bad debts (see instructions)	440,104	27.00
27.01	Medicare allowable bad debts (see instructions)	677,084	27.01
28.00	Non-Medicare bad debt amount (see instructions)	8,426,282	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,647,048	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,562,237	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,124,027	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 7:24 am

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,531,625	2,531,625	-34,748	2,496,877	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		824,732	824,732	34,748	859,480	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,457,322	4,457,322	-224,997	4,232,325	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	224,997	224,997	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	235,963	15,003,602	15,239,565	-2	15,239,563	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,619,337	14,253,286	21,872,623	-106,317	21,766,306	5.00
7.00	00700	OPERATION OF PLANT	0	1,510,680	1,510,680	-110	1,510,570	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	355,409	355,409	0	355,409	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	552,540	23,729	576,269	0	576,269	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	87,796	84,178	171,974	-13,439	158,535	8.00
9.00	00900	HOUSEKEEPING	978,609	423,220	1,401,829	-2,666	1,399,163	9.00
10.00	01000	DIETARY	598,703	547,009	1,145,712	-980,539	165,173	10.00
11.00	01100	CAFETERIA	0	0	0	936,157	936,157	11.00
13.00	01300	NURSING ADMINISTRATION	740,597	5,953	746,550	0	746,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	660,565	3,931,218	4,591,783	-12,618	4,579,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	729,217	35,305	764,522	0	764,522	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,264,123	2,172,410	4,436,533	559,580	4,996,113	30.00
31.00	03100	INTENSIVE CARE UNIT	358,165	42,513	400,678	-10,980	389,698	31.00
43.00	04300	NURSERY	0	133,244	133,244	659,841	793,085	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,991,521	4,982,532	6,974,053	-3,594,613	3,379,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,337,181	268,092	1,605,273	-1,476,338	128,935	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,545,054	11,413,420	14,958,474	-270,403	14,688,071	54.00
60.00	06000	LABORATORY	1,646,009	2,308,515	3,954,524	35,473	3,989,997	60.00
65.00	06500	RESPIRATORY THERAPY	1,086,218	123,008	1,209,226	-24,409	1,184,817	65.00
66.00	06600	PHYSICAL THERAPY	1,095,479	41,715	1,137,194	50,390	1,187,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,568	10,887	339,455	-8,543	330,912	67.00
68.00	06800	SPEECH PATHOLOGY	103,098	1,619	104,717	-192	104,525	68.00
69.00	06900	ELECTROCARDIOLOGY	702,167	196,691	898,858	-28,980	869,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39	39	3,104,326	3,104,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,225,055	2,225,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	70,118	70,118	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,341,385	151,836	1,493,221	0	1,493,221	88.00
88.01	08801	MEDICAL ARTS CENTER	2,693,436	142,571	2,836,007	0	2,836,007	88.01
90.00	09000	CLINIC	2,512,310	1,082,606	3,594,916	-223,352	3,371,564	90.00
90.01	09001	WOUND CLINC	361,697	337,081	698,778	-274,120	424,658	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,322,309	2,992,143	5,314,452	-244,412	5,070,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	764,888	350,205	1,115,093	0	1,115,093	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,656,935	70,738,395	107,395,330	368,907	107,764,237	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,459,365	2,749,558	14,208,923	14,494	14,223,417	192.00
192.01	19201	PEDIATRICS	112,259	7,406	119,665	0	119,665	192.01
192.02	19202	BROOKVILLE	2,454,048	265,956	2,720,004	0	2,720,004	192.02
192.03	19203	RADIOLOGY - OSGOOD	107,065	12,248	119,313	0	119,313	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	400,059	726,163	1,126,222	-383,401	742,821	194.00
194.01	07951	COMMUNITY BENEFITS	389,119	154,864	543,983	0	543,983	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	33,550	151,083	184,633	0	184,633	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	230,014	23,709	253,723	0	253,723	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	122,559	172,243	294,802	0	294,802	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	51,964,973	75,001,625	126,966,598	0	126,966,598	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-497,136	1,999,741		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	859,480		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-8,685	4,223,640		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	224,997		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,172	15,230,391		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,764,591	15,001,715		5.00
7.00	00700	OPERATION OF PLANT	0	1,510,570		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	355,409		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	576,269		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	158,535		8.00
9.00	00900	HOUSEKEEPING	0	1,399,163		9.00
10.00	01000	DIETARY	0	165,173		10.00
11.00	01100	CAFETERIA	-294,499	641,658		11.00
13.00	01300	NURSING ADMINISTRATION	0	746,550		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	4,579,165		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,365	763,157		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,795,657	3,200,456		30.00
31.00	03100	INTENSIVE CARE UNIT	0	389,698		31.00
43.00	04300	NURSERY	-118,608	674,477		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-175,500	3,203,940		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	128,935		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,743,529	12,944,542		54.00
60.00	06000	LABORATORY	0	3,989,997		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,184,817		65.00
66.00	06600	PHYSICAL THERAPY	0	1,187,584		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,275	329,637		67.00
68.00	06800	SPEECH PATHOLOGY	0	104,525		68.00
69.00	06900	ELECTROCARDIOLOGY	-140,161	729,717		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,104,365		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,225,055		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,118		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,493,221		88.00
88.01	08801	MEDICAL ARTS CENTER	0	2,836,007		88.01
90.00	09000	CLINIC	-1,972,697	1,398,867		90.00
90.01	09001	WOUND CLINC	-59,928	364,730		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	-1,559,024	3,511,016		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,115,093		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,141,827	92,622,410		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,223,417		192.00
192.01	19201	PEDIATRICS	0	119,665		192.01
192.02	19202	BROOKVILLE	0	2,720,004		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	119,313		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	742,821		194.00
194.01	07951	COMMUNITY BENEFITS	0	543,983		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	184,633		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	253,723		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	-39,702	255,100		194.06
194.07	07957	FQHC	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,181,529	111,785,069		200.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 7:24 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	489,198	446,959		1.00
	0		489,198	446,959		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	610,289	62,824		1.00
2.00	NURSERY	43.00	598,255	61,586		2.00
	0		1,208,544	124,410		
	C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	140,021	243,380		1.00
	0		140,021	243,380		
	D - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,225,055		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,225,055		
	E - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	224,997		1.00
	0		0	224,997		
	F - CENTRAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,104,365		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	3,104,365		
	G - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	34,748		1.00
	0		0	34,748		
	H - IT RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	96,588	0		1.00
2.00	PHYSICAL THERAPY	66.00	60,303	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,494	0		3.00
4.00	WOUND CLINC	90.01	32,165	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	70,118	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	64,081	0		6.00
7.00	OPERATING ROOM	50.00	64,373	0		7.00
8.00	LABORATORY	60.00	84,322	0		8.00
	TOTALS		486,444	0		
500.00	Grand Total: Increases		2,324,207	6,403,914		500.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 7:24 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	489,198	446,959	0		1.00
	0		489,198	446,959			
	B - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,208,544	124,410	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,208,544	124,410			
	C - COMMUNITY RELATIONS						
1.00	COMMUNITY RELATIONS	194.00	140,021	243,380	0		1.00
	0		140,021	243,380			
	D - IMPLANTABLE SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	2,801	0		1.00
2.00	OPERATING ROOM	50.00	0	2,143,821	0		2.00
3.00	WOUND CLINC	90.01	0	78,433	0		3.00
	0		0	2,225,055			
	E - OFFSITE BUILDING DEPR RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	224,997	9		1.00
	0		0	224,997			
	F - CENTRAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,274	0		2.00
3.00	OPERATION OF PLANT	7.00	0	110	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	13,439	0		4.00
5.00	HOUSEKEEPING	9.00	0	2,666	0		5.00
6.00	DIETARY	10.00	0	44,382	0		6.00
7.00	PHARMACY	15.00	0	12,618	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	174,813	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	10,980	0		9.00
10.00	OPERATING ROOM	50.00	0	1,515,165	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	143,384	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	366,991	0		12.00
13.00	LABORATORY	60.00	0	48,849	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	24,409	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	9,913	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	8,543	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	192	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	28,980	0		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39	0		19.00
20.00	CLINIC	90.00	0	223,352	0		20.00
21.00	WOUND CLINC	90.01	0	227,852	0		21.00
22.00	EMERGENCY	91.00	0	244,412	0		22.00
	0		0	3,104,365			
	G - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	34,748	9		1.00
	0		0	34,748			
	H - IT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	486,444	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		486,444	0			
500.00	Grand Total: Decreases		2,324,207	6,403,914			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 7:24 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,798,684	1,100,773	0	1,100,773	0	1.00
2.00	Land Improvements	278,583	24,409	0	24,409	0	2.00
3.00	Buildings and Fixtures	81,712,152	2,368,269	0	2,368,269	0	3.00
4.00	Building Improvements	0	637,141	0	637,141	0	4.00
5.00	Fixed Equipment	7,615,900	201,771	0	201,771	0	5.00
6.00	Movable Equipment	68,407,153	1,336,350	0	1,336,350	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,812,472	5,668,713	0	5,668,713	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	163,812,472	5,668,713	0	5,668,713	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,899,457	0	1.00
2.00	Land Improvements	302,992	0	2.00
3.00	Buildings and Fixtures	84,080,421	0	3.00
4.00	Building Improvements	637,141	0	4.00
5.00	Fixed Equipment	7,817,671	0	5.00
6.00	Movable Equipment	69,743,503	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	169,481,185	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	169,481,185	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 7:24 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,805,592	0	726,033	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	824,732	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,457,322	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	7,087,646	0	726,033	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,531,625	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	824,732	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,457,322	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	7,813,679	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2024 7:24 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	65,417,862	0	65,417,862	0.396022	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	20,287,256	0	20,287,256	0.122813	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	79,482,410	0	79,482,410	0.481165	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	165,187,528	0	165,187,528	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,770,844	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	859,480	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,223,640	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	224,997	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	7,078,961	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	228,897	0	0	0	1,999,741	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	859,480	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,223,640	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	224,997	2.01
3.00	Total (sum of lines 1-2)	228,897	0	0	0	7,307,858	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 7:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-7,509,759			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	-292,911	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		0		0.00	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	-1,588	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 7:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-8,685	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	-9,172	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
35.00	OTHER OPERATING - OTHER OPER. - MISC	B	-8,176	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	OTHER OPERATING - OTHER OPER. - MEDI	B	-1,365	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	OTHER OPERATING - OTHER OPER. - PHYS	B	-34,615	RADIOLOGY-DIAGNOSTIC	54.00	0	38.00
39.00	OTHER OPERATING - OTHER OPER. - OCCU	B	-1,275	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	OTHER OPERATING - OTHER OPER. - OUTP	B	-20,502	CLINIC	90.00	0	40.00
43.00	INTEREST OFFSET	A	-497,136	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00	LOBBYING EXPENSE	A	-8,545	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MEDICAL STAFF RETENTION COST	A	-38,477	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	HAF	A	-6,636,161	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	TELEPHONE & TV OFFSET	A	-1,819	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	BOUTIQUE OFFSET	A	-180	RADIOLOGY-DIAGNOSTIC	54.00	0	45.03
45.04	HOSPITALIST OFFSET	A	-48	ADULTS & PEDIATRICS	30.00	0	45.04
45.05	MEDICAL STAFF PLACEMENT FEE	A	-71,413	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.07	FOUNDATION GRANT EXPENSE TO HOSPITAL	A	-39,702	FOUNDATION	194.06	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,181,529				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 7:24 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	66,000	0	66,000	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,813,609	1,795,609	18,000	0	0	2.00
3.00	43.00	NURSERY	118,608	118,608	0	0	0	3.00
4.00	50.00	OPERATING ROOM	230,500	175,500	55,000	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,766,734	1,708,734	58,000	0	0	5.00
6.00	60.00	LABORATORY	68,410	0	68,410	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	170,161	140,161	30,000	0	0	7.00
8.00	90.00	CLINIC	1,987,195	1,952,195	35,000	0	0	8.00
9.00	90.01	WOUND CLINC	59,928	59,928	0	0	0	9.00
10.00	91.00	EMERGENCY	3,103,179	1,559,024	1,544,155	0	0	10.00
200.00			9,384,324	7,509,759	1,874,565		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	WOUND CLINC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,795,609		2.00
3.00	43.00	NURSERY	0	0	0	118,608		3.00
4.00	50.00	OPERATING ROOM	0	0	0	175,500		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,708,734		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	140,161		7.00
8.00	90.00	CLINIC	0	0	0	1,952,195		8.00
9.00	90.01	WOUND CLINC	0	0	0	59,928		9.00
10.00	91.00	EMERGENCY	0	0	0	1,559,024		10.00
200.00			0	0	0	7,509,759		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,999,741	1,999,741				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	859,480	0	859,480			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,223,640			4,223,640		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	224,997			0	224,997	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,230,391	8,555	0	18,069	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,001,715	286,574	0	605,272	0	5.00
7.00	00700	OPERATION OF PLANT	1,510,570	362,751	0	766,158	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	355,409	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	576,269	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	158,535	22,708	0	47,962	0	8.00
9.00	00900	HOUSEKEEPING	1,399,163	31,566	0	66,671	0	9.00
10.00	01000	DIETARY	165,173	21,230	0	44,839	0	10.00
11.00	01100	CAFETERIA	641,658	53,592	0	113,192	0	11.00
13.00	01300	NURSING ADMINISTRATION	746,550	771	0	1,628	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,566	0	20,204	0	14.00
15.00	01500	PHARMACY	4,579,165	7,633	0	16,121	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	763,157	35,004	0	73,931	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,200,456	186,479	0	393,862	0	30.00
31.00	03100	INTENSIVE CARE UNIT	389,698	17,552	0	37,072	0	31.00
43.00	04300	NURSERY	674,477	9,313	0	19,670	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,203,940	44,367	0	93,708	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	128,935	16,933	0	35,764	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,944,542	247,350	0	522,427	0	54.00
60.00	06000	LABORATORY	3,989,997	43,976	0	92,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,184,817	33,626	0	71,022	0	65.00
66.00	06600	PHYSICAL THERAPY	1,187,584	69,679	0	147,168	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	329,637	14,772	0	31,200	0	67.00
68.00	06800	SPEECH PATHOLOGY	104,525	13,496	0	28,505	0	68.00
69.00	06900	ELECTROCARDIOLOGY	729,717	25,526	0	53,913	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,104,365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,225,055	47,261	0	99,820	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,118	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,493,221	0	48,662	0	12,739	88.00
88.01	08801	MEDICAL ARTS CENTER	2,836,007	0	147,300	0	38,561	88.01
90.00	09000	CLINIC	1,398,867	177,078	0	374,005	0	90.00
90.01	09001	WOUND CLINC	364,730	9,970	0	21,058	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,511,016	112,972	0	238,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,115,093	15,139	0	31,974	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,622,410	1,925,439	195,962	4,066,703	51,300	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,223,417	18,108	501,621	38,247	131,315	192.00
192.01	19201	PEDIATRICS	119,665	28,647	0	60,506	0	192.01
192.02	19202	BROOKVILLE	2,720,004	1,339	158,889	2,829	41,594	192.02
192.03	19203	RADIOLOGY - OSGOOD	119,313	0	3,008	0	788	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	742,821	3,829	0	8,087	0	194.00
194.01	07951	COMMUNITY BENEFITS	543,983	17,413	0	36,779	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	184,633	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	253,723	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	255,100	4,966	0	10,489	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	111,785,069	1,999,741	859,480	4,223,640	224,997	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,257,015					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,145,081	18,038,642	18,038,642			5.00
7.00	00700	OPERATION OF PLANT	0	2,639,479	507,889	3,147,368		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	355,409	68,388	0	423,797	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	162,967	739,236	142,244	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	25,895	255,100	49,086	53,262	0	8.00
9.00	00900	HOUSEKEEPING	288,632	1,786,032	343,668	74,040	0	9.00
10.00	01000	DIETARY	32,298	263,540	50,710	49,794	0	10.00
11.00	01100	CAFETERIA	144,285	952,727	183,324	125,701	0	11.00
13.00	01300	NURSING ADMINISTRATION	218,432	967,381	186,143	1,808	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,770	5,728	22,437	0	14.00
15.00	01500	PHARMACY	194,828	4,797,747	923,182	17,902	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	215,076	1,087,168	209,193	82,102	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	866,682	4,647,479	894,268	437,391	0	30.00
31.00	03100	INTENSIVE CARE UNIT	105,638	549,960	105,823	41,169	0	31.00
43.00	04300	NURSERY	176,450	879,910	169,312	21,844	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,367	3,948,382	759,748	104,065	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,940	219,572	42,250	39,717	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,070	14,788,389	2,845,582	580,166	0	54.00
60.00	06000	LABORATORY	510,346	4,637,200	892,290	103,146	0	60.00
65.00	06500	RESPIRATORY THERAPY	320,370	1,609,835	309,764	78,871	0	65.00
66.00	06600	PHYSICAL THERAPY	340,887	1,745,318	335,834	163,433	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,908	472,517	90,922	34,649	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,408	176,934	34,046	31,655	0	68.00
69.00	06900	ELECTROCARDIOLOGY	207,098	1,016,254	195,548	59,872	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,104,365	597,342	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,372,136	456,446	110,852	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,681	90,799	17,472	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	395,629	1,950,251	375,267	0	23,994	88.00
88.01	08801	MEDICAL ARTS CENTER	794,405	3,816,273	734,327	0	72,632	88.01
90.00	09000	CLINIC	740,983	2,690,933	517,789	415,339	0	90.00
90.01	09001	WOUND CLINC	116,166	511,924	98,504	23,386	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	684,944	4,547,539	875,037	264,978	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	225,597	1,387,803	267,041	35,508	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,779,063	87,076,004	13,284,167	2,973,087	96,626	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,384,118	18,296,826	3,520,632	42,474	247,342	192.00
192.01	19201	PEDIATRICS	33,110	241,928	46,552	67,193	0	192.01
192.02	19202	BROOKVILLE	723,799	3,648,454	702,036	3,142	78,346	192.02
192.03	19203	RADIOLOGY - OSGOOD	31,578	154,687	29,765	0	1,483	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	76,696	831,433	159,984	8,981	0	194.00
194.01	07951	COMMUNITY BENEFITS	114,767	712,942	137,184	40,843	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	9,895	194,528	37,431	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	67,841	321,564	61,875	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	36,148	306,703	59,016	11,648	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,257,015	111,785,069	18,038,642	3,147,368	423,797	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	881,480					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	9,165	366,613				8.00
9.00	00900	HOUSEKEEPING	12,740	71,815	2,288,295			9.00
10.00	01000	DIETARY	8,568	464	34,571	407,647		10.00
11.00	01100	CAFETERIA	21,629	2,072	87,271	0	1,372,724	11.00
13.00	01300	NURSING ADMINISTRATION	311	0	1,255	0	21,796	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,861	0	15,578	0	0	14.00
15.00	01500	PHARMACY	3,080	0	12,429	0	22,454	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,127	0	57,001	0	48,403	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,261	73,302	303,670	389,151	217,096	30.00
31.00	03100	INTENSIVE CARE UNIT	7,084	4,523	28,583	18,496	15,463	31.00
43.00	04300	NURSERY	3,759	16,170	15,166	0	24,633	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,906	51,071	72,249	0	181,851	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,834	2,766	27,575	0	5,264	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,828	55,173	402,796	0	149,075	54.00
60.00	06000	LABORATORY	17,748	0	71,611	0	178,355	60.00
65.00	06500	RESPIRATORY THERAPY	13,571	2,087	54,758	0	29,651	65.00
66.00	06600	PHYSICAL THERAPY	28,122	19,755	113,467	0	85,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,962	4,479	24,056	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,447	1,732	21,977	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,302	9,557	41,568	0	27,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,074	0	76,962	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	85,949	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	381	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	279	0	0	0	88.01
90.00	09000	CLINIC	71,467	14,542	288,360	0	0	90.00
90.01	09001	WOUND CLINC	4,024	3,814	16,236	0	42,975	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	45,594	24,484	183,967	0	101,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,110	0	24,652	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	511,574	358,466	1,975,758	407,647	1,237,879	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	261,566	118	221,028	0	90,802	192.00
192.01	19201	PEDIATRICS	11,562	0	46,650	0	4,154	192.01
192.02	19202	BROOKVILLE	86,201	7,989	2,181	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	40	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,545	0	6,235	0	15,997	194.00
194.01	07951	COMMUNITY BENEFITS	7,028	0	28,356	0	17,354	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	1,768	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	2,004	0	8,087	0	4,770	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	881,480	366,613	2,288,295	407,647	1,372,724	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	1,178,694					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,374				14.00
15.00	01500	PHARMACY	50,012	0	5,826,806			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,497,994		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	291,777	0	0	985,522	8,314,917	30.00
31.00	03100	INTENSIVE CARE UNIT	34,432	0	0	0	805,533	31.00
43.00	04300	NURSERY	54,906	0	0	0	1,185,700	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	110,379	5,245,651	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,805	0	0	0	355,783	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,883	0	0	201,047	19,310,939	54.00
60.00	06000	LABORATORY	205,890	0	0	0	6,106,240	60.00
65.00	06500	RESPIRATORY THERAPY	66,041	0	0	0	2,164,578	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,491,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	632,585	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	271,791	68.00
69.00	06900	ELECTROCARDIOLOGY	48,316	0	0	11,826	1,420,467	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,374	0	0	3,779,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,035,470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,826,806	0	6,021,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,349,893	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	0	4,623,511	88.01
90.00	09000	CLINIC	0	0	0	55,189	4,053,619	90.00
90.01	09001	WOUND CLINC	0	0	0	0	700,863	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	226,632	0	0	122,205	6,392,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,721,114	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,178,694	77,374	5,826,806	1,486,168	80,982,816	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11,826	22,692,614	192.00
192.01	19201	PEDIATRICS	0	0	0	0	418,039	192.01
192.02	19202	BROOKVILLE	0	0	0	0	4,528,349	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	185,975	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,024,175	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	943,707	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	233,727	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	383,439	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	392,228	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,178,694	77,374	5,826,806	1,497,994	111,785,069	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	8,314,917		30.00
31.00	03100	INTENSIVE CARE UNIT	0	805,533		31.00
43.00	04300	NURSERY	0	1,185,700		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,245,651		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	355,783		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,310,939		54.00
60.00	06000	LABORATORY	0	6,106,240		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,164,578		65.00
66.00	06600	PHYSICAL THERAPY	0	2,491,878		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	632,585		67.00
68.00	06800	SPEECH PATHOLOGY	0	271,791		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,420,467		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,779,081		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,035,470		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,021,026		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,349,893		88.00
88.01	08801	MEDICAL ARTS CENTER	0	4,623,511		88.01
90.00	09000	CLINIC	0	4,053,619		90.00
90.01	09001	WOUND CLINC	0	700,863		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	0	6,392,177		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,721,114		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	80,982,816		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,692,614		192.00
192.01	19201	PEDIATRICS	0	418,039		192.01
192.02	19202	BROOKVILLE	0	4,528,349		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	185,975		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	1,024,175		194.00
194.01	07951	COMMUNITY BENEFITS	0	943,707		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	233,727		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	383,439		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	0	392,228		194.06
194.07	07957	FQHC	0	0		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	111,785,069		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,555	0	18,069	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	286,574	0	605,272	0	5.00
7.00	00700	OPERATION OF PLANT	0	362,751	0	766,158	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,708	0	47,962	0	8.00
9.00	00900	HOUSEKEEPING	0	31,566	0	66,671	0	9.00
10.00	01000	DIETARY	0	21,230	0	44,839	0	10.00
11.00	01100	CAFETERIA	0	53,592	0	113,192	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	771	0	1,628	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,566	0	20,204	0	14.00
15.00	01500	PHARMACY	0	7,633	0	16,121	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,004	0	73,931	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	186,479	0	393,862	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,552	0	37,072	0	31.00
43.00	04300	NURSERY	0	9,313	0	19,670	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,367	0	93,708	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,933	0	35,764	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	247,350	0	522,427	0	54.00
60.00	06000	LABORATORY	0	43,976	0	92,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	33,626	0	71,022	0	65.00
66.00	06600	PHYSICAL THERAPY	0	69,679	0	147,168	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,772	0	31,200	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,496	0	28,505	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,526	0	53,913	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	47,261	0	99,820	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	48,662	0	12,739	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	147,300	0	38,561	88.01
90.00	09000	CLINIC	0	177,078	0	374,005	0	90.00
90.01	09001	WOUND CLINC	0	9,970	0	21,058	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	112,972	0	238,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	15,139	0	31,974	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,925,439	195,962	4,066,703	51,300	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,108	501,621	38,247	131,315	192.00
192.01	19201	PEDIATRICS	0	28,647	0	60,506	0	192.01
192.02	19202	BROOKVILLE	0	1,339	158,889	2,829	41,594	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	3,008	0	788	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	3,829	0	8,087	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	17,413	0	36,779	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	4,966	0	10,489	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,999,741	859,480	4,223,640	224,997	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,624	26,624				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	891,846	3,746	895,592			5.00
7.00	00700	OPERATION OF PLANT	1,128,909	0	25,215	1,154,124		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	3,395	0	3,395	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	285	7,062	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	70,670	45	2,437	19,531	0	8.00
9.00	00900	HOUSEKEEPING	98,237	504	17,062	27,150	0	9.00
10.00	01000	DIETARY	66,069	56	2,518	18,259	0	10.00
11.00	01100	CAFETERIA	166,784	252	9,101	46,094	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,399	381	9,241	663	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,770	0	284	8,228	0	14.00
15.00	01500	PHARMACY	23,754	340	45,833	6,565	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108,935	376	10,386	30,106	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	580,341	1,513	44,397	160,389	0	30.00
31.00	03100	INTENSIVE CARE UNIT	54,624	184	5,254	15,097	0	31.00
43.00	04300	NURSERY	28,983	308	8,406	8,010	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	138,075	1,059	37,719	38,160	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,697	66	2,098	14,564	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	769,777	1,875	141,273	212,744	0	54.00
60.00	06000	LABORATORY	136,857	891	44,299	37,823	0	60.00
65.00	06500	RESPIRATORY THERAPY	104,648	559	15,379	28,922	0	65.00
66.00	06600	PHYSICAL THERAPY	216,847	595	16,673	59,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,972	169	4,514	12,705	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,001	53	1,690	11,608	0	68.00
69.00	06900	ELECTROCARDIOLOGY	79,439	362	9,708	21,955	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	29,656	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	147,081	0	22,661	40,649	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36	867	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	61,401	691	18,631	0	192	88.00
88.01	08801	MEDICAL ARTS CENTER	185,861	1,387	36,457	0	582	88.01
90.00	09000	CLINIC	551,083	1,294	25,706	152,303	0	90.00
90.01	09001	WOUND CLINC	31,028	203	4,890	8,575	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	351,579	1,196	43,443	97,166	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	47,113	394	13,258	13,021	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,239,404	18,820	659,513	1,090,217	774	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	689,291	5,895	174,822	15,575	1,981	192.00
192.01	19201	PEDIATRICS	89,153	58	2,311	24,639	0	192.01
192.02	19202	BROOKVILLE	204,651	1,264	34,854	1,152	628	192.02
192.03	19203	RADIOLOGY - OSGOOD	3,796	55	1,478	0	12	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	11,916	134	7,943	3,293	0	194.00
194.01	07951	COMMUNITY BENEFITS	54,192	200	6,811	14,977	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	17	1,858	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	118	3,072	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	15,455	63	2,930	4,271	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,307,858	26,624	895,592	1,154,124	3,395	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	7,347					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	76	92,759				8.00
9.00	00900	HOUSEKEEPING	106	18,170	161,229			9.00
10.00	01000	DIETARY	71	117	2,436	89,526		10.00
11.00	01100	CAFETERIA	180	524	6,149	0	229,084	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	88	0	3,637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32	0	1,098	0	0	14.00
15.00	01500	PHARMACY	26	0	876	0	3,747	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118	0	4,016	0	8,078	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	627	18,549	21,396	85,464	36,232	30.00
31.00	03100	INTENSIVE CARE UNIT	59	1,144	2,014	4,062	2,580	31.00
43.00	04300	NURSERY	31	4,091	1,069	0	4,111	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149	12,922	5,091	0	30,348	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57	700	1,943	0	878	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832	13,960	28,378	0	24,878	54.00
60.00	06000	LABORATORY	148	0	5,046	0	29,764	60.00
65.00	06500	RESPIRATORY THERAPY	113	528	3,858	0	4,948	65.00
66.00	06600	PHYSICAL THERAPY	234	4,998	7,995	0	14,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	50	1,133	1,695	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45	438	1,548	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86	2,418	2,929	0	4,543	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	159	0	5,423	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,343	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	96	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	71	0	0	0	88.01
90.00	09000	CLINIC	596	3,679	20,317	0	0	90.00
90.01	09001	WOUND CLINC	34	965	1,144	0	7,172	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	380	6,195	12,962	0	16,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	51	0	1,737	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,263	90,698	139,208	89,526	206,581	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,181	30	15,573	0	15,153	192.00
192.01	19201	PEDIATRICS	96	0	3,287	0	693	192.01
192.02	19202	BROOKVILLE	718	2,021	154	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	10	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	13	0	439	0	2,670	194.00
194.01	07951	COMMUNITY BENEFITS	59	0	1,998	0	2,896	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	295	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	17	0	570	0	796	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	7,347	92,759	161,229	89,526	229,084	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	16,412					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,412				14.00
15.00	01500	PHARMACY	696	0	81,837			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	162,015		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,062	0	0	106,589	1,059,559	30.00
31.00	03100	INTENSIVE CARE UNIT	479	0	0	0	85,497	31.00
43.00	04300	NURSERY	765	0	0	0	55,774	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	11,938	275,461	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164	0	0	0	73,167	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,630	0	0	21,744	1,218,091	54.00
60.00	06000	LABORATORY	2,867	0	0	0	257,695	60.00
65.00	06500	RESPIRATORY THERAPY	920	0	0	0	159,875	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	321,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	66,238	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	57,383	68.00
69.00	06900	ELECTROCARDIOLOGY	673	0	0	1,279	123,392	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,412	0	0	69,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	215,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	81,837	0	97,083	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	81,011	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	0	224,358	88.01
90.00	09000	CLINIC	0	0	0	5,969	760,947	90.00
90.01	09001	WOUND CLINC	0	0	0	0	54,011	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,156	0	0	13,217	546,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	75,574	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,412	39,412	81,837	160,736	5,878,045	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,279	921,780	192.00
192.01	19201	PEDIATRICS	0	0	0	0	120,237	192.01
192.02	19202	BROOKVILLE	0	0	0	0	245,442	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	5,351	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	26,408	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	81,133	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	2,170	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	3,190	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	24,102	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,412	39,412	81,837	162,015	7,307,858	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,059,559		30.00
31.00	03100	INTENSIVE CARE UNIT	0	85,497		31.00
43.00	04300	NURSERY	0	55,774		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	275,461		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	73,167		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,218,091		54.00
60.00	06000	LABORATORY	0	257,695		60.00
65.00	06500	RESPIRATORY THERAPY	0	159,875		65.00
66.00	06600	PHYSICAL THERAPY	0	321,615		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66,238		67.00
68.00	06800	SPEECH PATHOLOGY	0	57,383		68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,392		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69,068		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	215,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,083		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	81,011		88.00
88.01	08801	MEDICAL ARTS CENTER	0	224,358		88.01
90.00	09000	CLINIC	0	760,947		90.00
90.01	09001	WOUND CLINC	0	54,011		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	0	546,273		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	75,574		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,878,045		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	921,780		192.00
192.01	19201	PEDIATRICS	0	120,237		192.01
192.02	19202	BROOKVILLE	0	245,442		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	5,351		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	26,408		194.00
194.01	07951	COMMUNITY BENEFITS	0	81,133		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	2,170		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	3,190		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	0	24,102		194.06
194.07	07957	FQHC	0	0		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,307,858		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	158,249					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	90,855				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			158,249			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	90,855		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	677	0	677	0	51,729,010	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,678	0	22,678	0	7,272,914	5.00
7.00	00700	OPERATION OF PLANT	28,706	0	28,706	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	552,540	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	0	1,797	0	87,796	8.00
9.00	00900	HOUSEKEEPING	2,498	0	2,498	0	978,609	9.00
10.00	01000	DIETARY	1,680	0	1,680	0	109,505	10.00
11.00	01100	CAFETERIA	4,241	0	4,241	0	489,198	11.00
13.00	01300	NURSING ADMINISTRATION	61	0	61	0	740,597	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757	0	757	0	0	14.00
15.00	01500	PHARMACY	604	0	604	0	660,565	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	0	2,770	0	729,217	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,757	0	14,757	0	2,938,493	30.00
31.00	03100	INTENSIVE CARE UNIT	1,389	0	1,389	0	358,165	31.00
43.00	04300	NURSERY	737	0	737	0	598,255	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,511	0	3,511	0	2,055,894	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,340	0	1,340	0	128,637	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,574	0	19,574	0	3,641,642	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,730,331	60.00
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	1,086,218	65.00
66.00	06600	PHYSICAL THERAPY	5,514	0	5,514	0	1,155,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	328,568	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	103,098	68.00
69.00	06900	ELECTROCARDIOLOGY	2,020	0	2,020	0	702,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,740	0	3,740	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	70,118	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,144	0	5,144	1,341,385	88.00
88.01	08801	MEDICAL ARTS CENTER	0	15,571	0	15,571	2,693,436	88.01
90.00	09000	CLINIC	14,013	0	14,013	0	2,512,310	90.00
90.01	09001	WOUND CLINC	789	0	789	0	393,862	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	8,940	0	8,940	0	2,322,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,198	0	1,198	0	764,888	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,369	20,715	152,369	20,715	36,546,499	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,433	53,026	1,433	53,026	11,473,859	192.00
192.01	19201	PEDIATRICS	2,267	0	2,267	0	112,259	192.01
192.02	19202	BROOKVILLE	106	16,796	106	16,796	2,454,048	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	318	0	318	107,065	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	303	0	303	0	260,038	194.00
194.01	07951	COMMUNITY BENEFITS	1,378	0	1,378	0	389,119	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	33,550	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	230,014	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	393	0	393	0	122,559	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	1,999,741	859,480	4,223,640	224,997	15,257,015	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.636674	9.459909	26.689837	2.476440	0.294941	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
204.00		Cost to be allocated (per Wkst. B, Part II)					26,624	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000515	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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,038,642	93,746,427				5.00
7.00	00700	OPERATION OF PLANT	0	2,639,479	106,188			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	355,409	0	90,855		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	739,236	0	0	172,838	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	255,100	1,797	0	1,797	8.00
9.00	00900	HOUSEKEEPING	0	1,786,032	2,498	0	2,498	9.00
10.00	01000	DIETARY	0	263,540	1,680	0	1,680	10.00
11.00	01100	CAFETERIA	0	952,727	4,241	0	4,241	11.00
13.00	01300	NURSING ADMINISTRATION	0	967,381	61	0	61	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,770	757	0	757	14.00
15.00	01500	PHARMACY	0	4,797,747	604	0	604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,087,168	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,647,479	14,757	0	14,757	30.00
31.00	03100	INTENSIVE CARE UNIT	0	549,960	1,389	0	1,389	31.00
43.00	04300	NURSERY	0	879,910	737	0	737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,948,382	3,511	0	3,511	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,572	1,340	0	1,340	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,788,389	19,574	0	19,574	54.00
60.00	06000	LABORATORY	0	4,637,200	3,480	0	3,480	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,609,835	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,745,318	5,514	0	5,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	472,517	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	176,934	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,016,254	2,020	0	2,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,104,365	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,372,136	3,740	0	3,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	90,799	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,950,251	0	5,144	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	3,816,273	0	15,571	0	88.01
90.00	09000	CLINIC	0	2,690,933	14,013	0	14,013	90.00
90.01	09001	WOUND CLINC	0	511,924	789	0	789	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,547,539	8,940	0	8,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,387,803	1,198	0	1,198	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,038,642	69,037,362	100,308	20,715	100,308	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,296,826	1,433	53,026	51,287	192.00
192.01	19201	PEDIATRICS	0	241,928	2,267	0	2,267	192.01
192.02	19202	BROOKVILLE	0	3,648,454	106	16,796	16,902	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	154,687	0	318	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	831,433	303	0	303	194.00
194.01	07951	COMMUNITY BENEFITS	0	712,942	1,378	0	1,378	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	194,528	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	321,564	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	306,703	393	0	393	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)		18,038,642	3,147,368	423,797	881,480	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.192420	29.639583	4.664542	5.100036	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		895,592	1,154,124	3,395	7,347	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.009553	10.868686	0.037367	0.042508	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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	324,151					8.00
9.00	00900	HOUSEKEEPING	63,497	111,201				9.00
10.00	01000	DIETARY	410	1,680	16,706			10.00
11.00	01100	CAFETERIA	1,832	4,241	0	33,380		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	530	267,592	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	757	0	0	0	14.00
15.00	01500	PHARMACY	0	604	0	546	11,354	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,770	0	1,177	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,813	14,757	15,948	5,279	66,240	30.00
31.00	03100	INTENSIVE CARE UNIT	3,999	1,389	758	376	7,817	31.00
43.00	04300	NURSERY	14,297	737	0	599	12,465	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,156	3,511	0	4,422	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,446	1,340	0	128	2,680	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,783	19,574	0	3,625	42,881	54.00
60.00	06000	LABORATORY	0	3,480	0	4,337	46,742	60.00
65.00	06500	RESPIRATORY THERAPY	1,845	2,661	0	721	14,993	65.00
66.00	06600	PHYSICAL THERAPY	17,467	5,514	0	2,090	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,960	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,531	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,450	2,020	0	662	10,969	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,740	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,090	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	337	0	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	247	0	0	0	0	88.01
90.00	09000	CLINIC	12,858	14,013	0	0	0	90.00
90.01	09001	WOUND CLINC	3,372	789	0	1,045	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	21,648	8,940	0	2,474	51,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,198	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	316,948	96,013	16,706	30,101	267,592	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104	10,741	0	2,208	0	192.00
192.01	19201	PEDIATRICS	0	2,267	0	101	0	192.01
192.02	19202	BROOKVILLE	7,064	106	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	35	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	303	0	389	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,378	0	422	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	43	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	393	0	116	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	366,613	2,288,295	407,647	1,372,724	1,178,694	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.130995	20.578007	24.401233	41.124146	4.404818	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,759	161,229	89,526	229,084	16,412	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.286160	1.449888	5.358913	6.862912	0.061332	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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	102		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0		88.01
90.00	09000	CLINIC	0	0	28		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6		192.00
192.01	19201	PEDIATRICS	0	0	0		192.01
192.02	19202	BROOKVILLE	0	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	0	0	0		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0		194.04
194.05	07955	MMHCB RHC	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0		194.06
194.07	07957	FQHC	0	0	0		194.07
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)	77,374	5,826,806	1,497,994		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	773.740000	58,268.060000	1,971.044737		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,412	81,837	162,015		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:24 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	394.120000	818.370000	213.177632		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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,314,917		8,314,917	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	805,533		805,533	0	0	31.00
43.00	04300	NURSERY	1,185,700		1,185,700	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,245,651		5,245,651	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,783		355,783	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,310,939		19,310,939	0	0	54.00
60.00	06000	LABORATORY	6,106,240		6,106,240	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,164,578	0	2,164,578	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,491,878	0	2,491,878	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	632,585	0	632,585	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	271,791	0	271,791	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,420,467		1,420,467	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,779,081		3,779,081	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,035,470		3,035,470	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,021,026		6,021,026	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,349,893		2,349,893	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	4,623,511		4,623,511	0	0	88.01
90.00	09000	CLINIC	4,053,619		4,053,619	0	0	90.00
90.01	09001	WOUND CLINC	700,863		700,863	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,392,177		6,392,177	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,250,561		3,250,561		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,721,114		1,721,114		0	116.00
200.00		Subtotal (see instructions)	84,233,377	0	84,233,377	0	0	200.00
201.00		Less Observation Beds	3,250,561		3,250,561		0	201.00
202.00		Total (see instructions)	80,982,816	0	80,982,816	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,063,773		7,063,773			30.00
31.00	03100	INTENSIVE CARE UNIT	612,274		612,274			31.00
43.00	04300	NURSERY	2,964,445		2,964,445			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,908,123	18,073,585	20,981,708	0.250011	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	284,795	85,271	370,066	0.961404	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,542,371	108,859,308	111,401,679	0.173345	0.000000	54.00
60.00	06000	LABORATORY	4,499,147	48,388,988	52,888,135	0.115456	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,550,191	1,767,654	3,317,845	0.652405	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	174,546	5,280,843	5,455,389	0.456774	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,257	1,092,244	1,236,501	0.511593	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	30,796	447,442	478,238	0.568317	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	371,688	7,006,128	7,377,816	0.192532	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,375,261	4,734,370	6,109,631	0.618545	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	336,675	3,403,898	3,740,573	0.811499	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,751,990	12,246,695	15,998,685	0.376345	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,749,457	2,749,457			88.00
88.01	08801	MEDICAL ARTS CENTER	0	4,411,276	4,411,276			88.01
90.00	09000	CLINIC	1,000	7,833,634	7,834,634	0.517397	0.000000	90.00
90.01	09001	WOUND CLINC	0	2,297,809	2,297,809	0.305014	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	1,470,690	17,048,162	18,518,852	0.345171	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	876,534	4,542,742	5,419,276	0.599815	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,910,610	1,910,610			116.00
200.00		Subtotal (see instructions)	30,958,556	252,180,116	283,138,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,958,556	252,180,116	283,138,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	MEDICAL ARTS CENTER			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,314,917		8,314,917	0	8,314,917	30.00
31.00	03100	INTENSIVE CARE UNIT	805,533		805,533	0	805,533	31.00
43.00	04300	NURSERY	1,185,700		1,185,700	0	1,185,700	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,245,651		5,245,651	0	5,245,651	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,783		355,783	0	355,783	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,310,939		19,310,939	0	19,310,939	54.00
60.00	06000	LABORATORY	6,106,240		6,106,240	0	6,106,240	60.00
65.00	06500	RESPIRATORY THERAPY	2,164,578	0	2,164,578	0	2,164,578	65.00
66.00	06600	PHYSICAL THERAPY	2,491,878	0	2,491,878	0	2,491,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	632,585	0	632,585	0	632,585	67.00
68.00	06800	SPEECH PATHOLOGY	271,791	0	271,791	0	271,791	68.00
69.00	06900	ELECTROCARDIOLOGY	1,420,467		1,420,467	0	1,420,467	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,779,081		3,779,081	0	3,779,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,035,470		3,035,470	0	3,035,470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,021,026		6,021,026	0	6,021,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,349,893		2,349,893	0	2,349,893	88.00
88.01	08801	MEDICAL ARTS CENTER	4,623,511		4,623,511	0	4,623,511	88.01
90.00	09000	CLINIC	4,053,619		4,053,619	0	4,053,619	90.00
90.01	09001	WOUND CLINC	700,863		700,863	0	700,863	90.01
90.02	09002	BEHAVIORAL HEALTH	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,392,177		6,392,177	0	6,392,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,250,561		3,250,561		3,250,561	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,721,114		1,721,114		1,721,114	116.00
200.00		Subtotal (see instructions)	84,233,377	0	84,233,377	0	84,233,377	200.00
201.00		Less Observation Beds	3,250,561		3,250,561		3,250,561	201.00
202.00		Total (see instructions)	80,982,816	0	80,982,816	0	80,982,816	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,063,773		7,063,773			30.00
31.00	03100	INTENSIVE CARE UNIT	612,274		612,274			31.00
43.00	04300	NURSERY	2,964,445		2,964,445			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,908,123	18,073,585	20,981,708	0.250011	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	284,795	85,271	370,066	0.961404	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,542,371	108,859,308	111,401,679	0.173345	0.000000	54.00
60.00	06000	LABORATORY	4,499,147	48,388,988	52,888,135	0.115456	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,550,191	1,767,654	3,317,845	0.652405	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	174,546	5,280,843	5,455,389	0.456774	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,257	1,092,244	1,236,501	0.511593	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	30,796	447,442	478,238	0.568317	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	371,688	7,006,128	7,377,816	0.192532	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,375,261	4,734,370	6,109,631	0.618545	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	336,675	3,403,898	3,740,573	0.811499	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,751,990	12,246,695	15,998,685	0.376345	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,749,457	2,749,457	0.854675	0.000000	88.00
88.01	08801	MEDICAL ARTS CENTER	0	4,411,276	4,411,276	1.048112	0.000000	88.01
90.00	09000	CLINIC	1,000	7,833,634	7,834,634	0.517397	0.000000	90.00
90.01	09001	WOUND CLINC	0	2,297,809	2,297,809	0.305014	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	1,470,690	17,048,162	18,518,852	0.345171	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	876,534	4,542,742	5,419,276	0.599815	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,910,610	1,910,610			116.00
200.00		Subtotal (see instructions)	30,958,556	252,180,116	283,138,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,958,556	252,180,116	283,138,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	275,461	20,981,708	0.013129	330,193	4,335	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,167	370,066	0.197713	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,218,091	111,401,679	0.010934	394,227	4,310	54.00
60.00	06000	LABORATORY	257,695	52,888,135	0.004872	882,699	4,301	60.00
65.00	06500	RESPIRATORY THERAPY	159,875	3,317,845	0.048186	518,616	24,990	65.00
66.00	06600	PHYSICAL THERAPY	321,615	5,455,389	0.058954	77,673	4,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,238	1,236,501	0.053569	59,328	3,178	67.00
68.00	06800	SPEECH PATHOLOGY	57,383	478,238	0.119988	10,978	1,317	68.00
69.00	06900	ELECTROCARDIOLOGY	123,392	7,377,816	0.016725	132,174	2,211	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,068	6,109,631	0.011305	338,345	3,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	215,973	3,740,573	0.057738	100,265	5,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,083	15,998,685	0.006068	961,401	5,834	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,011	2,749,457	0.029464	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	224,358	4,411,276	0.050860	0	0	88.01
90.00	09000	CLINIC	760,947	7,834,634	0.097126	0	0	90.00
90.01	09001	WOUND CLINC	54,011	2,297,809	0.023505	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	546,273	18,518,852	0.029498	5,663	167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	414,216	5,419,276	0.076434	12,570	961	92.00
200.00		Total (lines 50 through 199)	5,015,857	270,587,570		3,824,132	65,797	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,981,708	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	370,066	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	111,401,679	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	52,888,135	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,317,845	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,455,389	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,236,501	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	478,238	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,377,816	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,109,631	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,740,573	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,998,685	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,749,457	0.000000	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	4,411,276	0.000000	88.01
90.00	09000	CLINIC	0	0	0	7,834,634	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	2,297,809	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	18,518,852	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,419,276	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,587,570		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	330,193	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	394,227	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	882,699	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	518,616	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	77,673	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	59,328	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,978	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	132,174	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	338,345	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	100,265	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	961,401	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	5,663	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	12,570	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,824,132	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.250011	0	3,751,927	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.961404	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173345	0	38,107,000	0	0	54.00
60.00	06000	LABORATORY	0.115456	0	12,610,940	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.652405	0	534,068	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.456774	0	1,694,979	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511593	0	322,039	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.568317	0	26,756	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192532	0	1,903,650	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.618545	0	1,143,096	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.811499	0	1,054,813	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376345	0	4,632,020	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	MEDICAL ARTS CENTER						88.01
90.00	09000	CLINIC	0.517397	0	2,333,484	0	0	90.00
90.01	09001	WOUND CLINC	0.305014	0	913,683	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.345171	0	3,794,856	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599815	0	1,217,739	0	0	92.00
200.00		Subtotal (see instructions)		0	74,041,050	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	74,041,050	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	938,023	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,605,658	0		54.00
60.00	06000	LABORATORY	1,456,009	0		60.00
65.00	06500	RESPIRATORY THERAPY	348,429	0		65.00
66.00	06600	PHYSICAL THERAPY	774,222	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	164,753	0		67.00
68.00	06800	SPEECH PATHOLOGY	15,206	0		68.00
69.00	06900	ELECTROCARDIOLOGY	366,514	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	707,056	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	855,980	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,743,238	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	MEDICAL ARTS CENTER				88.01
90.00	09000	CLINIC	1,207,338	0		90.00
90.01	09001	WOUND CLINC	278,686	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	1,309,874	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	730,418	0		92.00
200.00		Subtotal (see instructions)	17,501,404	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	17,501,404	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,951	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,349	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	325	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	277	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,193	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)	325	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	266.32	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)	8,314,917	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)	73,771	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)	545,814	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,769,103	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)	7,769,103	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,452.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,732,761	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,732,761	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	805,533	237	3,398.87	65	220,927	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)	1,350,628	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,304,316	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)	472,043	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	472,043	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)	2,238	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,452.44	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,250,561	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	1,059,559	8,314,917	0.127429	3,250,561	414,216	90.00
91.00	Nursing Program cost	0	8,314,917	0.000000	3,250,561	0	91.00
92.00	Allied health cost	0	8,314,917	0.000000	3,250,561	0	92.00
93.00	All other Medical Education	0	8,314,917	0.000000	3,250,561	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,951	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,349	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	325	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	277	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)	83	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)	672	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)	8,314,917	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)	476,268	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,838,649	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)	7,838,649	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,465.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	121,632	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)	121,632	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,185,700	672	1,764.43	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	805,533	237	3,398.87	6	20,393	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)	101,533	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)	243,558	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)	2,238	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,465.44	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 7:24 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,279,655	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	1,059,559	8,314,917	0.127429	3,279,655	417,923	90.00
91.00	Nursing Program cost	0	8,314,917	0.000000	3,279,655	0	91.00
92.00	Allied health cost	0	8,314,917	0.000000	3,279,655	0	92.00
93.00	All other Medical Education	0	8,314,917	0.000000	3,279,655	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,048,369		30.00
31.00	03100	INTENSIVE CARE UNIT		170,112		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250011	330,193	82,552	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.961404	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173345	394,227	68,337	54.00
60.00	06000	LABORATORY	0.115456	882,699	101,913	60.00
65.00	06500	RESPIRATORY THERAPY	0.652405	518,616	338,348	65.00
66.00	06600	PHYSICAL THERAPY	0.456774	77,673	35,479	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511593	59,328	30,352	67.00
68.00	06800	SPEECH PATHOLOGY	0.568317	10,978	6,239	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192532	132,174	25,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.618545	338,345	209,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.811499	100,265	81,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376345	961,401	361,818	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000		0	88.01
90.00	09000	CLINIC	0.517397	0	0	90.00
90.01	09001	WOUND CLINC	0.305014	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.345171	5,663	1,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599815	12,570	7,540	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,824,132	1,350,628	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,824,132		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250011	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.961404	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173345	18,833	3,265	54.00
60.00	06000	LABORATORY	0.115456	77,446	8,942	60.00
65.00	06500	RESPIRATORY THERAPY	0.652405	70,346	45,894	65.00
66.00	06600	PHYSICAL THERAPY	0.456774	47,249	21,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511593	43,435	22,221	67.00
68.00	06800	SPEECH PATHOLOGY	0.568317	2,300	1,307	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192532	6,989	1,346	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.618545	23,436	14,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.811499	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376345	154,922	58,304	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000		0	88.01
90.00	09000	CLINIC	0.517397	0	0	90.00
90.01	09001	WOUND CLINC	0.305014	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.345171	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599815	4,999	2,998	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		449,955	180,355	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)		449,955		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		109,366		30.00
31.00	03100	INTENSIVE CARE UNIT		18,199		31.00
43.00	04300	NURSERY		210,391		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250011	14,340	3,585	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.961404	50,503	48,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173345	31,460	5,453	54.00
60.00	06000	LABORATORY	0.115456	109,544	12,648	60.00
65.00	06500	RESPIRATORY THERAPY	0.652405	28,674	18,707	65.00
66.00	06600	PHYSICAL THERAPY	0.456774	1,173	536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511593	864	442	67.00
68.00	06800	SPEECH PATHOLOGY	0.568317	838	476	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192532	5,247	1,010	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.618545	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.811499	1,573	1,276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376345	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.854675	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	1.048112	0	0	88.01
90.00	09000	CLINIC	0.517397	0	0	90.00
90.01	09001	WOUND CLINC	0.305014	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.345171	25,627	8,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599815	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		269,843	101,533	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)		269,843		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | 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	0.250011	14,340	3,585	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.961404	50,503	48,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173345	31,460	5,453	54.00
60.00	06000	LABORATORY	0.115456	109,544	12,648	60.00
65.00	06500	RESPIRATORY THERAPY	0.652405	28,674	18,707	65.00
66.00	06600	PHYSICAL THERAPY	0.456774	1,173	536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511593	864	442	67.00
68.00	06800	SPEECH PATHOLOGY	0.568317	838	476	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192532	5,247	1,010	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.618545	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.811499	1,573	1,276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376345	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.854675	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	1.048112	0	0	88.01
90.00	09000	CLINIC	0.517397	0	0	90.00
90.01	09001	WOUND CLINC	0.305014	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.345171	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599815	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		244,216	92,687	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)		244,216		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,501,404	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)	17,501,404	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)	17,676,418	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)	165,287	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12,318,030	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,193,101	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)	5,193,101	30.00
31.00	Primary payer payments	1,048	31.00
32.00	Subtotal (line 30 minus line 31)	5,192,053	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)	652,469	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	424,105	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	543,089	36.00
37.00	Subtotal (see instructions)	5,616,158	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,616,158	40.00
40.01	Sequestration adjustment (see instructions)	112,323	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	6,629,607	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,125,772	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: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,064,401		6,629,607	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/28/2023	186,000		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)		186,000		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)		3,250,401		6,629,607	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		413,074		1,125,772	6.02
7.00	Total Medicare program liability (see instructions)		2,837,327		5,503,835	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: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		631,237		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		631,237		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		8,096		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		639,333		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: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	476,763	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	182,159	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	325	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)	658,922	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	658,922	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)	658,922	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	652,122	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)	398	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	259	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	398	0	18.00
19.00	Total (see instructions)	652,381	0	19.00
19.01	Sequestration adjustment (see instructions)	13,048	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	631,237	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)	8,096	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 7:24 am

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	92,687		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	92,687		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	92,687		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	92,687		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	92,687		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	92,687		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	92,687		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,304,316	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,304,316	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,337,359	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,337,359	19.00
20.00	Deductibles (exclude professional component)	450,980	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,886,379	22.00
23.00	Coinsurance	5,600	23.00
24.00	Subtotal (line 22 minus line 23)	2,880,779	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,236	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,453	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,380	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,895,232	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)	2,895,232	30.00
30.01	Sequestration adjustment (see instructions)	57,905	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,250,401	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)	-413,074	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: 15-1329	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 7:24 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	243,558		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	243,558	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	243,558	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	337,956		8.00
9.00	Ancillary service charges	269,843	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	607,799	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	607,799	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	364,241	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	243,558	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	243,558	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	243,558	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	243,558	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	243,558	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)	243,558	0	40.00
41.00	Interim payments	298,514	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-54,956	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 7:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,536,847	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	45,807,596	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,896,041	0	0	0	6.00
7.00	Inventory	1,360,638	0	0	0	7.00
8.00	Prepaid expenses	1,674,420	0	0	0	8.00
9.00	Other current assets	606,899	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)	27,090,359	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,899,457	0	0	0	12.00
13.00	Land improvements	302,992	0	0	0	13.00
14.00	Accumulated depreciation	-267,857	0	0	0	14.00
15.00	Buildings	84,080,421	0	0	0	15.00
16.00	Accumulated depreciation	-56,786,234	0	0	0	16.00
17.00	Leasehold improvements	637,141	0	0	0	17.00
18.00	Accumulated depreciation	-357,485	0	0	0	18.00
19.00	Fixed equipment	7,817,671	0	0	0	19.00
20.00	Accumulated depreciation	-5,594,489	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	69,743,503	0	0	0	23.00
24.00	Accumulated depreciation	-56,346,932	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)	50,128,188	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	101,386,557	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	101,386,557	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	178,605,104	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,787,657	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	7,536,764	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,022,994	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,347,415	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,990,368	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,990,368	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,337,783	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	153,267,321				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)	153,267,321	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	178,605,104	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 7:24 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		138,512,947		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,754,374				2.00
3.00	Total (sum of line 1 and line 2)		153,267,321		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)		153,267,321		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)		153,267,321		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: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 7:24 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,519,025		6,519,025	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	687,325		687,325	5.00
6.00	Swing bed - NF	585,812		585,812	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)	7,792,162		7,792,162	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	700,918		700,918	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)	700,918		700,918	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,493,080		8,493,080	17.00
18.00	Ancillary services	19,308,860	204,481,521	223,790,381	18.00
19.00	Outpatient services	1,545,774	40,242,175	41,787,949	19.00
20.00	RURAL HEALTH CLINIC	0	2,749,457	2,749,457	20.00
20.01	MEDICAL ARTS CENTER	0	4,411,276	4,411,276	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,910,610	1,910,610	26.00
27.00	OTHER PRO FEES	557,036	32,520,114	33,077,150	27.00
27.01	PRO FEES	2,283,390	17,668,498	19,951,888	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,188,140	303,983,651	336,171,791	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,966,598		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)		126,966,598		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/29/2024 7:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	336,171,791	1.00
2.00	Less contractual allowances and discounts on patients' accounts	208,260,817	2.00
3.00	Net patient revenues (line 1 minus line 2)	127,910,974	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,966,598	4.00
5.00	Net income from service to patients (line 3 minus line 4)	944,376	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,860,453	24.00
24.01	CONTRIBUTIONS	189,758	24.01
24.02	UNREALIZED GAIN, DERIVATIVE	11,719,597	24.02
24.03	UNREALIZED GAIN, INVESTMENTS	35,624	24.03
24.04	TEMPORARILY RESTRICTED ASSETS	4,566	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	13,809,998	25.00
26.00	Total (line 5 plus line 25)	14,754,374	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)	14,754,374	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	165,862	193,454	359,316	0	359,316	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	48,234	48,234	0	48,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	90,516	90,516	0	90,516	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	18,000	18,000	0	18,000	26.00
27.00	NURSE PRACTITIONER**	6,357	0	6,357	0	6,357	27.00
28.00	REGISTERED NURSE**	405,470	0	405,470	0	405,470	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	63,819	0	63,819	0	63,819	33.00
34.00	SPIRITUAL COUNSELING**	31,432	0	31,432	0	31,432	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	91,949	0	91,949	0	91,949	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	764,889	350,204	1,115,093	0	1,115,093	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	359,316		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	48,234		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	90,516		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	18,000		26.00
27.00	NURSE PRACTITIONER**	0	6,357		27.00
28.00	REGISTERED NURSE**	0	405,470		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	63,819		33.00
34.00	SPIRITUAL COUNSELING**	0	31,432		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	91,949		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,115,093		100.00

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-2 | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	18,000	18,000	0	18,000	26.00
27.00	NURSE PRACTITIONER	6,356	0	6,356	0	6,356	27.00
28.00	REGISTERED NURSE	405,431	0	405,431	0	405,431	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	63,813	0	63,813	0	63,813	33.00
34.00	SPIRITUAL COUNSELING	31,429	0	31,429	0	31,429	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	91,940	0	91,940	0	91,940	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	598,969	18,000	616,969	0	616,969	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	18,000		26.00
27.00	NURSE PRACTITIONER	0	6,356		27.00
28.00	REGISTERED NURSE	0	405,431		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	63,813		33.00
34.00	SPIRITUAL COUNSELING	0	31,429		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	91,940		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	616,969		100.00

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-3 Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	1	0	1	0	1	27.00
28.00	REGISTERED NURSE	39	0	39	0	39	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	6	0	6	0	6	33.00
34.00	SPIRITUAL COUNSELING	3	0	3	0	3	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9	0	9	0	9	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	58	0	58	0	58	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	1		27.00
28.00	REGISTERED NURSE	0	39		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	6		33.00
34.00	SPIRITUAL COUNSELING	0	3		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	9		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	58		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

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

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-5

Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	15,139	15,139	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	31,974	31,974	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	225,597	225,597	3.00
4.00	ADMINISTRATIVE & GENERAL	359,316	267,041	626,357	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	41,618	41,618	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	24,652	24,652	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	48,234		48,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	90,516	0	90,516	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	616,969		616,969	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	58		58	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,115,093	606,021	1,721,114	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,139	15,139				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	31,974		31,974			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	225,597	0	0	225,597		3.00
4.00	ADMINISTRATIVE & GENERAL	626,357	0	0	0	626,357	4.00
5.00	PLANT OPERATION & MAINTENANCE	41,618	15,139	31,974	0	88,731	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	24,652	0	0	0	24,652	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	48,234	0	0	0	48,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	90,516	0	0	0	90,516	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	616,969			225,575	842,544	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	58	0	0	22	80	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,721,114	15,139	31,974	225,597	1,721,114	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	626,357					4.00
5.00	PLANT OPERATION & MAINTENANCE	50,767	139,498				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	14,104	0		38,756		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	27,597	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	51,788	139,498		38,756		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	482,055					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	46	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	626,357	139,498	0	38,756	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6 Part I
Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			75,831		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	75,823	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	8	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	75,831	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	320,558					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	320,527	0	0		1,720,949	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	31	0	0	0	165	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	320,558	0	0	0	1,721,114	100.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2024 7:24 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,139					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		31,974				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	225,597			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-626,357	1,094,757	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,139	31,974	0	0	88,731	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	24,652	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	48,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	90,516	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			225,575	0	842,544	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	22	0	80	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	15,139	31,974	225,597		626,357	100.00
101.00	UNIT COST MULTIPLIER	1.000000	1.000000	1.000000		0.572142	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2024 7:24 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	76,993					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		45,750			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	76,993		45,750		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	139,498	0	38,756	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.811827	0.000000	0.847126	0.000000	0.000000	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2024 7:24 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			89,515			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	167,983	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	89,506	0	167,967	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	9	0	16	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	75,831	0	320,558	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.847132	0.000000	1.908276	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2024 7:24 am

Hospice I

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-7

Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.456774	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.511593	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.568317	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.376345	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.115456	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.618545	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-8 | Date/Time Prepared: 5/29/2024 7:24 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,720,949	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			10,486	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			164.12	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	9,727	95		9.00
10.00	Program cost (line 8 times line 9)	1,596,395	15,591		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			165	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			1	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			165.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,721,114	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			10,487	22.00
23.00	Average cost per diem (line 21 divided by line 22)			164.12	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:24 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	180,496	0	180,496	0	180,496	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	407,479	0	407,479	0	407,479	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	88,798	0	88,798	0	88,798	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	346,344	0	346,344	0	346,344	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,023,117	0	1,023,117	0	1,023,117	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	124,495	124,495	0	124,495	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124,495	124,495	0	124,495	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,023,117	124,495	1,147,612	0	1,147,612	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	8,998	8,998	0	8,998	29.00
30.00	Administrative Costs	318,264	18,347	336,611	0	336,611	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	318,264	27,345	345,609	0	345,609	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,341,381	151,840	1,493,221	0	1,493,221	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:24 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	180,496		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	407,479		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	88,798		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	346,344		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,023,117		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	124,495		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124,495		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,147,612		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	8,998		29.00
30.00	Administrative Costs	0	336,611		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	345,609		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,493,221		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:24 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,095,990	0	1,095,990	0	1,095,990	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103,157	0	103,157	0	103,157	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	307,668	0	307,668	0	307,668	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
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	719,266	0	719,266	0	719,266	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,226,081	0	2,226,081	0	2,226,081	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	112,998	112,998	0	112,998	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	112,998	112,998	0	112,998	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,226,081	112,998	2,339,079	0	2,339,079	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	12,155	12,155	0	12,155	29.00
30.00	Administrative Costs	467,356	17,417	484,773	0	484,773	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	467,356	29,572	496,928	0	496,928	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,693,437	142,570	2,836,007	0	2,836,007	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:24 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,095,990		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	103,157		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	307,668		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	719,266		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,226,081		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	112,998		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	112,998		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,339,079		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	12,155		29.00
30.00	Administrative Costs	0	484,773		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	496,928		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,836,007		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:24 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.68	2,536	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.56	9,170	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.24	11,706		4	11,706	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.24	11,706			11,706	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)	1,147,612	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)	1,147,612	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)	345,609	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	856,672	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,202,281	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,202,281	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,202,281	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,349,893	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:24 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.33	15,857	1	3		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.60	1,405	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.93	17,262		4	17,262	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.93	17,262			17,262	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,339,079	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)	2,339,079	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)	496,928	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,787,504	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,284,432	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,284,432	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,284,432	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,623,511	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,349,893	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		17,763	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,332,130	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,706	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,706	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		199.23	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	236.04	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	199.23	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,440	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	286,891	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	112	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	22,314	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	22,314	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	309,205	16.00
16.01	Total program charges (see instructions)(from contractor's records)		403,429	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,204	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,485	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.)		210,081	16.04
16.05	Total program cost (see instructions)	0	225,566	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,119	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		70,271	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		225,566	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		26,064	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)		251,630	22.00
23.00	Allowable bad debts (see instructions)		1,062	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		690	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		207	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		252,320	26.00
26.01	Sequestration adjustment (see instructions)		5,046	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		288,869	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)		-41,595	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: 15-1329 Component CCN: 15-8567	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:24 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,623,511	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			19,309	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,604,202	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,262	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)			17,262	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			266.72	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	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,786		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	729,036		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	729,036		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,560,681		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		121,969		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		56,975		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.)		468,434		16.04
16.05	Total program cost (see instructions)	0	525,409		16.05
17.00	Primary payer amounts		86		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		86,519		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		270,432		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		525,323		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,524		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)		531,847		22.00
23.00	Allowable bad debts (see instructions)		919		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		597		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		113		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)		532,444		26.00
26.01	Sequestration adjustment (see instructions)		10,649		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		511,657		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)		10,138		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: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,023,117	1,023,117	1,023,117	1,023,117	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000310	0.001317	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	317	1,347	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,053	2,958	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,370	4,305	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,147,612	1,147,612	1,147,612	1,147,612	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,202,281	1,202,281	1,202,281	1,202,281	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003808	0.003751	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,578	4,510	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,948	8,815	0	0	10.00
11.00	Total number of injections/infusions (from your records)	99	17	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	90.38	518.53	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	48	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,175	24,889	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)		17,763	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)		26,064	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:24 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,226,081	2,226,081	2,226,081	2,226,081	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000004	0.001568	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	9	3,490	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	99	6,171	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	108	9,661	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,339,079	2,339,079	2,339,079	2,339,079	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,284,432	2,284,432	2,284,432	2,284,432	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000046	0.004130	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	105	9,435	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	213	19,096	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	363	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	213.00	52.61	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	124	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	6,524	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)		19,309	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6,524	16.00

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

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/29/2024 7:24 am

RHC I | Cost

		Part B	
		mm/dd/yyyy	Amount
		1.00	2.00
1.00	Total interim payments paid to hospital-based RHC/FQHC		288,869
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
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)		
	Program to Provider		
3.01			0
3.02			0
3.03			0
3.04			0
3.05			0
	Provider to Program		
3.50			0
3.51			0
3.52			0
3.53			0
3.54			0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		288,869
	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)		
	Program to Provider		
5.01			0
5.02			0
5.03			0
	Provider to Program		
5.50			0
5.51			0
5.52			0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		
6.01	SETTLEMENT TO PROVIDER		0
6.02	SETTLEMENT TO PROGRAM		41,595
7.00	Total Medicare program liability (see instructions)		247,274

			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: 15-1329 Component CCN: 15-8567	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:24 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		511,657	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)		511,657	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		10,138	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		521,795	7.00

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