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: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 1/25/2024 11:51 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received: 12/01/2023
7. Contractor No. 08001
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 MEMORIAL HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	850,532	44,833	0	0	1.00
2.00	SUBPROVIDER - IPF	0	4,954	0		0	2.00
3.00	SUBPROVIDER - IRF	0	5,770	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		7,678		0	10.00
10.01	RURAL HEALTH CLINIC II	0		10,126		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	861,256	62,638	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2024 11:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	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)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	218	167	0	5	1,700	167	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	79		25.00

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	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.	Y	Y		56.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2024 11:51 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

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

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

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

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.50	0.000000	66.00

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

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	2.61	11.63	0.183287	67.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

				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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,147,044	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2024 11:51 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HOSPITAL AND HEALTH CENTER	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 800 W 9TH STREET	PO Box:		142.00
143.00	City: JASPER	State: IN	Zip Code: 47546	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 1/25/2024 11:51 am

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/03/2023	Y	11/03/2023	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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 1/25/2024 11:51 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			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 REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 1/25/2024 11:51 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.			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

HFS Supplemental Information | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part IX Date/Time Prepared: 1/25/2024 11:51 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 1/25/2024 11:51 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	70	25,550	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		70	25,550	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		96	35,040	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	14	5,110		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		128				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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2024 11:51 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)	2,663	104	6,387			1.00
2.00	HMO and other (see instructions)	1,576	1,872				2.00
3.00	HMO IPF Subprovider	11	0				3.00
4.00	HMO IRF Subprovider	34	79				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,663	104	6,387			7.00
8.00	INTENSIVE CARE UNIT	1,601	29	3,105			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		85	1,662			13.00
14.00	Total (see instructions)	4,264	218	11,154	14.47	938.60	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	138	375	923	0.27	13.36	16.00
17.00	SUBPROVIDER - IRF	585	0	987	0.00	7.37	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,221	79	3,847	0.00	19.42	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	10,833	0	18,799	0.00	31.49	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)			20			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,324	0	4,522	0.00	5.37	26.00
26.01	RURAL HEALTH CLINIC II	1,680	0	3,971	0.00	6.14	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)				14.74	1,021.75	27.00
28.00	Observation Bed Days		502	3,568			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	167	672			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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2024 11:51 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	1,556	175	2,602	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,556	175	2,602	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	45	188	502	16.00
17.00	SUBPROVIDER - IRF	0.00	0	53	0	93	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 1/25/2024 11:51 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	105,184,512	-1,042,381	104,142,131	2,096,092.00	49.68	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		3,510,599	0	3,510,599	31,871.20	110.15	3.00
4.00	Physician-Part A - Administrative		149,707	0	149,707	433.00	345.74	4.00
4.01	Physicians - Part A - Teaching		993,223	0	993,223	6,404.34	155.09	4.01
5.00	Physician and Non Physician-Part B		11,790,555	0	11,790,555	37,385.31	315.38	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		614,192	0	614,192	15,598.94	39.37	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		1,297,819	0	1,297,819	30,098.00	43.12	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,408,217	-19,273	1,388,944	39,316.00	35.33	9.00
10.00	Excluded area salaries (see instructions)		40,071,502	-85,178	39,986,324	746,762.00	53.55	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,049,953	0	6,049,953	101,970.49	59.33	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		120,996	0	120,996	1,015.00	119.21	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		16,182,323	0	16,182,323	450,080.67	35.95	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,090,525	0	13,090,525			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,773,590	0	7,773,590			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		331,627	0	331,627			21.00
22.00	Physician Part A - Administrative		4,364	0	4,364			22.00
22.01	Physician Part A - Teaching		67,634	0	67,634			22.01
23.00	Physician Part B		388,352	0	388,352			23.00
24.00	Wage-related costs (RHC/FQHC)		161,450	0	161,450			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		3,173,354	0	3,173,354			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 1/25/2024 11:51 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,772,100	-203,687	1,568,413	72,363.00	21.67	27.00
28.00	Administrative & General under contract (see inst.)		2,808,269	0	2,808,269	13,656.70	205.63	28.00
29.00	Maintenance & Repairs	6.00	633,083	-2,141	630,942	19,229.00	32.81	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	299,370	-7,234	292,136	15,823.00	18.46	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,342,800	0	1,342,800	70,696.44	18.99	33.00
34.00	Dietary	10.00	1,166,582	-944,098	222,484	9,906.00	22.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	920,900	920,900	42,856.00	21.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,001,282	-36,705	964,577	21,983.00	43.88	38.00
39.00	Central Services and Supply	14.00	326,883	-10,857	316,026	13,364.00	23.65	39.00
40.00	Pharmacy	15.00	2,148,469	-1,754,228	394,241	5,379.00	73.29	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 1/25/2024 11:51 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		91,129,193	-1,042,381	90,086,812	2,059,087.35	43.75	1.00
2.00	Excluded area salaries (see instructions)		41,479,719	-104,451	41,375,268	786,078.00	52.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)		49,649,474	-937,930	48,711,544	1,273,009.35	38.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		22,353,272	0	22,353,272	553,066.16	40.42	4.00
5.00	Subtotal wage-related costs (see inst.)		16,268,243	0	16,268,243	0.00	33.40	5.00
6.00	Total (sum of lines 3 thru 5)		88,270,989	-937,930	87,333,059	1,826,075.51	47.83	6.00
7.00	Total overhead cost (see instructions)		11,498,838	-2,038,050	9,460,788	285,256.14	33.17	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part IV Date/Time Prepared: 1/25/2024 11:51 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,671,252	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11,797,411	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	85,707	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1,405,725	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	343,326	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,437,849	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	76,271	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,817,541	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part V | Date/Time Prepared: 1/25/2024 11:51 am

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-4 | Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I | PPS

		1.00	
0.00	County	DUBOIS	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,708	154	2,032	4,894	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	441.00	25.00	331.00	797.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		4.88	0.00	4.88	5.00
6.00	Direct Nursing Service		11.97	0.00	11.97	6.00
7.00	Nursing Supervisor		0.80	0.00	0.80	7.00
8.00	Physical Therapy Service		6.39	0.00	6.39	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		3.71	0.00	3.71	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.22	0.00	0.22	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.17	0.00	0.17	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		2.35	0.00	2.35	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00

		CBSA Data	
		1.00	
	HOME HEALTH AGENCY CBSA CODES		
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.	1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99915	20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,649	1,433	83	36	4,201	21.00
22.00	Skilled Nursing Visit Charges	673,236	364,148	23,132	9,456	1,069,972	22.00
23.00	Physical Therapy Visits	1,689	1,497	43	22	3,251	23.00
24.00	Physical Therapy Visit Charges	455,232	402,891	11,567	5,918	875,608	24.00
25.00	Occupational Therapy Visits	620	1,148	10	19	1,797	25.00
26.00	Occupational Therapy Visit Charges	167,374	309,109	2,690	5,111	484,284	26.00
27.00	Speech Pathology Visits	32	39	1	2	74	27.00
28.00	Speech Pathology Visit Charges	8,608	10,491	269	538	19,906	28.00
29.00	Medical Social Service Visits	11	10	0	0	21	29.00
30.00	Medical Social Service Visit Charges	3,366	3,060	0	0	6,426	30.00
31.00	Home Health Aide Visits	674	805	3	7	1,489	31.00
32.00	Home Health Aide Visit Charges	78,858	94,185	351	819	174,213	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,675	4,932	140	86	10,833	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,386,674	1,183,884	38,009	21,842	2,630,409	35.00
36.00	Total Number of Episodes (standard/non outlier)	5,675		140	27	5,842	36.00
37.00	Total Number of Outlier Episodes		4,932		59	4,991	37.00
38.00	Total Non-Routine Medical Supply Charges	28,448	10,001	451	209	39,109	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 1/25/2024 11:51 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			522 SOUTH MAPLE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRENCH LICK		IN	47432	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		ORANGE				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	16:00	08:00	12:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 1/25/2024 11:51 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	06:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 1/25/2024 11:51 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 COOPER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115
Component CCN: 15-8508

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
1/25/2024 11:51 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	13:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 1/25/2024 11:51 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.215854	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	16,258,166	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	67,346,479	6.00
7.00	Medicaid cost (line 1 times line 6)	14,537,007	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	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 (line 11 minus line 9; if < zero then enter zero)	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 (line 15 minus line 13; if < zero then enter zero)	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,365,734	518,394	4,884,128	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	942,361	518,394	1,460,755	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 (line 21 minus line 22)	942,361	518,394	1,460,755	23.00

		1.00	
24.00	Does the amount on line 20 column 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
26.00	Total bad debt expense for the entire hospital complex (see instructions)	8,056,059	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	100,849	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	155,153	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,900,906	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,759,746	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,220,501	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,220,501	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,458,437	6,458,437	0	6,458,437	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,536,543	5,536,543	0	5,536,543	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,772,100	1,676,043	3,448,143	-174,570	3,273,573	5.00
6.00	00600	MAINTENANCE & REPAIRS	633,083	3,420,528	4,053,611	0	4,053,611	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	299,370	73,070	372,440	0	372,440	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	1,166,582	696,329	1,862,911	-1,502,479	360,432	10.00
11.00	01100	CAFETERIA	0	0	0	1,496,103	1,496,103	11.00
13.00	01300	NURSING ADMINISTRATION	1,001,282	120,837	1,122,119	-398	1,121,721	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	326,883	180,761	507,644	-11,231	496,413	14.00
15.00	01500	PHARMACY	2,148,469	20,288,346	22,436,815	-21,825,157	611,658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,297,819	1,297,819	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,362,936	1,423,996	2,786,932	-1,297,821	1,489,111	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,770,923	1,573,685	9,344,608	-2,377,908	6,966,700	30.00
31.00	03100	INTENSIVE CARE UNIT	2,814,077	318,453	3,132,530	-105,314	3,027,216	31.00
40.00	04000	SUBPROVIDER - IPF	1,438,493	79,978	1,518,471	-2,012	1,516,459	40.00
41.00	04100	SUBPROVIDER - IRF	578,298	139,497	717,795	-5,268	712,527	41.00
43.00	04300	NURSERY	0	0	0	723,084	723,084	43.00
44.00	04400	SKILLED NURSING FACILITY	1,408,217	207,507	1,615,724	-31,716	1,584,008	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,758,754	10,006,932	15,765,686	-74,793	15,690,893	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,446,167	1,446,167	52.00
53.00	05300	ANESTHESIOLOGY	3,948,599	524,861	4,473,460	-107,456	4,366,004	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,493,170	1,927,846	9,421,016	-367,175	9,053,841	54.00
56.00	05600	RADIOISOTOPE	202,106	726,567	928,673	-922	927,751	56.00
60.00	06000	LABORATORY	3,505,585	5,427,741	8,933,326	-525	8,932,801	60.00
65.00	06500	RESPIRATORY THERAPY	1,399,136	851,138	2,250,274	-35,117	2,215,157	65.00
66.00	06600	PHYSICAL THERAPY	3,108,298	219,969	3,328,267	-86,567	3,241,700	66.00
69.00	06900	ELECTROCARDIOLOGY	2,922,060	1,828,280	4,750,340	-80,815	4,669,525	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	115,643	57,066	172,709	0	172,709	69.02
69.03	06903	SLEEP LAB	253,074	12,345	265,419	0	265,419	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,810,928	1,810,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,285,095	5,285,095	0	5,285,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,223,968	22,223,968	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	418,977	125,603	544,580	0	544,580	88.00
88.01	08801	RURAL HEALTH CLINIC II	583,911	86,741	670,652	0	670,652	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	513,302	533,751	1,047,053	-139,991	907,062	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	2,826,357	1,054,875	3,881,232	-100,142	3,781,090	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,312,624	726,845	2,039,469	-479,738	1,559,731	90.04
90.05	09005	DIABETES MGMT CLINIC	64,012	3,590	67,602	0	67,602	90.05
91.00	09100	EMERGENCY	9,983,480	808,370	10,791,850	-261,619	10,530,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,899,672	172,787	3,072,459	-22,357	3,050,102	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,250,604	332,700	2,583,304	-75,831	2,507,473	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,280,077	72,907,112	145,187,189	-168,853	145,018,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	31,024,143	6,265,731	37,289,874	0	37,289,874	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	848,396	16,645	865,041	0	865,041	192.01
194.00	07950	LODGE	5,100	12,896	17,996	0	17,996	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	138,271	9,766	148,037	0	148,037	194.02
194.03	07953	MKT/PHY SERVICES	263,730	56,190	319,920	0	319,920	194.03
194.04	07954	COMMUNITY EDUCATION	346,737	139,971	486,708	0	486,708	194.04
194.05	07955	VOLUNTEER	249,873	15,162	265,035	0	265,035	194.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	168,853	168,853	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	28,185	194,352	222,537	0	222,537	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	105,184,512	79,617,825	184,802,337	0	184,802,337	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	801,902	7,260,339		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,759	5,539,302		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,213,703	32,213,703		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,574,802	27,848,375		5.00
6.00	00600	MAINTENANCE & REPAIRS	1,050,666	5,104,277		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	372,440		8.00
9.00	00900	HOUSEKEEPING	1,668,838	1,668,838		9.00
10.00	01000	DIETARY	-1,486	358,946		10.00
11.00	01100	CAFETERIA	-632,765	863,338		11.00
13.00	01300	NURSING ADMINISTRATION	-13,643	1,108,078		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,082	493,331		14.00
15.00	01500	PHARMACY	-473,546	138,112		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,535,525	1,535,525		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,297,819		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-232,721	1,256,390		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,750	6,964,950		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,027,216		31.00
40.00	04000	SUBPROVIDER - IPF	-132,851	1,383,608		40.00
41.00	04100	SUBPROVIDER - IRF	-27,667	684,860		41.00
43.00	04300	NURSERY	0	723,084		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,584,008		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,530,409	14,160,484		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,446,167		52.00
53.00	05300	ANESTHESIOLOGY	-4,074,744	291,260		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,714,173	4,339,668		54.00
56.00	05600	RADIOISOTOPE	0	927,751		56.00
60.00	06000	LABORATORY	-208,790	8,724,011		60.00
65.00	06500	RESPIRATORY THERAPY	-1,210	2,213,947		65.00
66.00	06600	PHYSICAL THERAPY	-317,794	2,923,906		66.00
69.00	06900	ELECTROCARDIOLOGY	-550,112	4,119,413		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	172,709		69.02
69.03	06903	SLEEP LAB	0	265,419		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,810,928		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,285,095		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,223,968		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-640	543,940		88.00
88.01	08801	RURAL HEALTH CLINIC II	-119	670,533		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-318,162	588,900		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	3,781,090		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	-315,699	1,244,032		90.04
90.05	09005	DIABETES MGMT CLINIC	0	67,602		90.05
91.00	09100	EMERGENCY	-5,591,828	4,938,403		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-235,803	2,814,299		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	2,507,473		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,469,201	187,487,537		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	37,289,874		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	865,041		192.01
194.00	07950	LODGE	0	17,996		194.00
194.01	07951	OTHER NRCC	0	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	148,037		194.02
194.03	07953	MKT/PHY SERVICES	3,602,354	3,922,274		194.03
194.04	07954	COMMUNITY EDUCATION	0	486,708		194.04
194.05	07955	VOLUNTEER	0	265,035		194.05
194.06	07956	MAB	0	0		194.06
194.07	07957	OFFSITE COVID SCREENING	0	168,853		194.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.08	07958	PUBLIC RELATIONS	0	0		194.08
194.09	07959	UNUSED SPACE	0	0		194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	222,537		194.10
194.11	07961	HOME OFFICE	0	0		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	46,071,555	230,873,892		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet Non-CMS W | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	PULMONARY	06901		69.01
69.02	CARDIOPULMONARY	06902		69.02
69.03	SLEEP LAB	06903		69.03
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
77.00	ALLOGENEIC HSCT ACQUISITION	07700		77.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	IMED	09001		90.01
90.02	ONCOLOGY	09002		90.02
90.03	OUTPATIENT CENTER	09003		90.03
90.04	HBURG URGENT CARE CLINIC	09004		90.04
90.05	DIABETES MGMT CLINIC	09005		90.05
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
101.00	HOME HEALTH AGENCY	10100		101.00
102.00	OPIOID TREATMENT PROGRAM	10200		102.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	19201		192.01
194.00	LODGE	07950		194.00
194.01	OTHER NRCC	07951		194.01
194.02	MEMORIAL HOSPITAL FOUNDATION	07952		194.02
194.03	MKT/PHY SERVICES	07953		194.03
194.04	COMMUNITY EDUCATION	07954		194.04
194.05	VOLUNTEER	07955		194.05

COST CENTERS USED IN COST REPORT | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet Non-CMS W | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
194.06	MAB	07956		194.06
194.07	OFFSITE COVID SCREENING	07957		194.07
194.08	PUBLIC RELATIONS	07958		194.08
194.09	UNUSED SPACE	07959		194.09
194.10	EMERGENCY PREPAREDNESS	07960		194.10
194.11	HOME OFFICE	07961		194.11
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/25/2024 11:51 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	637,747	85,337	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,275,493	170,674	2.00
	TOTALS		1,913,240	256,011	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	920,900	575,203	1.00
	TOTALS		920,900	575,203	
	C - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,810,928	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
23.00		0.00	0	0	23.00
	TOTALS		0	1,810,928	
	D - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,485,748	1.00
2.00	LABORATORY	60.00	0	39	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
	TOTALS		0	20,485,787	
	E - INTERN AND RESIDENT RECLASS				
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	1,297,819	1.00
	TOTALS		0	1,297,819	
	F - DISABILITY LEAVE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,294	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	2,141	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	7,234	3.00
4.00	DIETARY	10.00	0	23,198	4.00
5.00	NURSING ADMINISTRATION	13.00	0	36,705	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,857	6.00
7.00	PHARMACY	15.00	0	16,008	7.00
8.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	4,616	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	91,629	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	73,614	10.00
11.00	SUBPROVIDER - IPF	40.00	0	21,782	11.00
12.00	SUBPROVIDER - IRF	41.00	0	14,241	12.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/25/2024 11:51 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
13.00	SKILLED NURSING FACILITY	44.00	0	19,273		13.00
14.00	OPERATING ROOM	50.00	0	56,459		14.00
15.00	ANESTHESIOLOGY	53.00	0	46,047		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	68,866		16.00
17.00	LABORATORY	60.00	0	26,593		17.00
18.00	RESPIRATORY THERAPY	65.00	0	26,131		18.00
19.00	PHYSICAL THERAPY	66.00	0	33,082		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	68,882		20.00
21.00	RURAL HEALTH CLINIC II	88.01	0	1,018		21.00
22.00	CLINIC	90.00	0	10,055		22.00
23.00	ONCOLOGY	90.02	0	44,231		23.00
24.00	HBURG URGENT CARE CLINIC	90.04	0	19,264		24.00
25.00	EMERGENCY	91.00	0	67,613		25.00
26.00	AMBULANCE SERVICES	95.00	0	33,872		26.00
27.00	HOME HEALTH AGENCY	101.00	0	3,199		27.00
28.00	PHYSICIANS PRIVATE OFFICES	192.00	0	149,692		28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	8,832		29.00
30.00	COMMUNITY EDUCATION	194.04	0	1,105		30.00
31.00	VOLUNTEER	194.05	0	9,848		31.00
	TOTALS		0	1,042,381		
	G - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,738,220	0		1.00
	TOTALS		1,738,220	0		
	H - VOLUNTEER/GUEST SVC					
1.00	OFFSITE COVID SCREENING	194.07	157,393	11,460		1.00
	TOTALS		157,393	11,460		
500.00	Grand Total: Increases		4,729,753	25,479,589		500.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/25/2024 11:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,913,240	256,011	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,913,240	256,011			
	B - CAFETERIA						
1.00	DIETARY	10.00	920,900	575,203	0		1.00
	TOTALS		920,900	575,203			
	C - BILLABLE SUPPLES						
1.00	NURSING ADMINISTRATION	13.00	0	398	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,867	0		2.00
3.00	PHARMACY	15.00	0	87	0		3.00
4.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	208,402	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	105,280	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	1,970	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	5,255	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	31,710	0		9.00
10.00	OPERATING ROOM	50.00	0	74,543	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	2,013	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	196,698	0		12.00
13.00	RADIOISOTOPE	56.00	0	918	0		13.00
14.00	LABORATORY	60.00	0	564	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	34,178	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	83,586	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	51,730	0		17.00
18.00	CLINIC	90.00	0	129,128	0		18.00
19.00	ONCOLOGY	90.02	0	100,142	0		19.00
20.00	HBURG URGENT CARE CLINIC	90.04	0	466,095	0		20.00
21.00	EMERGENCY	91.00	0	245,725	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	11,097	0		22.00
23.00	HOME HEALTH AGENCY	101.00	0	50,540	0		23.00
	TOTALS		0	1,810,928			
	D - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,717	0		1.00
2.00	DIETARY	10.00	0	6,376	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	364	0		3.00
4.00	PHARMACY	15.00	0	20,086,850	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	255	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	34	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	42	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	13	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	6	0		9.00
10.00	OPERATING ROOM	50.00	0	250	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	105,443	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	170,477	0		12.00
13.00	RADIOISOTOPE	56.00	0	4	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	939	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	2,981	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	29,085	0		16.00
17.00	CLINIC	90.00	0	10,863	0		17.00
18.00	HBURG URGENT CARE CLINIC	90.04	0	13,643	0		18.00
19.00	EMERGENCY	91.00	0	15,894	0		19.00
20.00	AMBULANCE SERVICES	95.00	0	11,260	0		20.00
21.00	HOME HEALTH AGENCY	101.00	0	25,291	0		21.00
	TOTALS		0	20,485,787			
	E - INTERN AND RESIDENT RECLASS						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	1,297,819	0		1.00
	TOTALS		0	1,297,819			
	F - DISABILITY LEAVE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	46,294	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	2,141	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	7,234	0	0		3.00
4.00	DIETARY	10.00	23,198	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	36,705	0	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	10,857	0	0		6.00
7.00	PHARMACY	15.00	16,008	0	0		7.00
8.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	4,616	0	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	91,629	0	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	73,614	0	0		10.00
11.00	SUBPROVIDER - IPF	40.00	21,782	0	0		11.00
12.00	SUBPROVIDER - IRF	41.00	14,241	0	0		12.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/25/2024 11:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	SKILLED NURSING FACILITY	44.00	19,273	0	0		13.00
14.00	OPERATING ROOM	50.00	56,459	0	0		14.00
15.00	ANESTHESIOLOGY	53.00	46,047	0	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	68,866	0	0		16.00
17.00	LABORATORY	60.00	26,593	0	0		17.00
18.00	RESPIRATORY THERAPY	65.00	26,131	0	0		18.00
19.00	PHYSICAL THERAPY	66.00	33,082	0	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	68,882	0	0		20.00
21.00	RURAL HEALTH CLINIC II	88.01	1,018	0	0		21.00
22.00	CLINIC	90.00	10,055	0	0		22.00
23.00	ONCOLOGY	90.02	44,231	0	0		23.00
24.00	HBURG URGENT CARE CLINIC	90.04	19,264	0	0		24.00
25.00	EMERGENCY	91.00	67,613	0	0		25.00
26.00	AMBULANCE SERVICES	95.00	33,872	0	0		26.00
27.00	HOME HEALTH AGENCY	101.00	3,199	0	0		27.00
28.00	PHYSICIANS PRIVATE OFFICES	192.00	149,692	0	0		28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	8,832	0	0		29.00
30.00	COMMUNITY EDUCATION	194.04	1,105	0	0		30.00
31.00	VOLUNTEER	194.05	9,848	0	0		31.00
	TOTALS		1,042,381	0			
	G - PHARMACY RECLASS						
1.00	PHARMACY	15.00	1,738,220	0	0		1.00
	TOTALS		1,738,220	0			
	H - VOLUNTEER/GUEST SVC						
1.00	ADMINISTRATIVE & GENERAL	5.00	157,393	11,460	0		1.00
	TOTALS		157,393	11,460			
500.00	Grand Total: Decreases		5,772,134	24,437,208			500.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 1/25/2024 11:51 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - LABOR AND DELIVERY								
1.00	NURSERY	43.00	637,747	85,337	ADULTS & PEDIATRICS	30.00	1,913,240	256,011	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,275,493	170,674		0.00	0	0	2.00
	TOTALS		1,913,240	256,011	TOTALS		1,913,240	256,011	
	B - CAFETERIA								
1.00	CAFETERIA	11.00	920,900	575,203	DIETARY	10.00	920,900	575,203	1.00
	TOTALS		920,900	575,203	TOTALS		920,900	575,203	
	C - BILLABLE SUPPLES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,810,928	NURSING ADMINISTRATION	13.00	0	398	1.00
2.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	10,867	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	87	3.00
4.00		0.00	0	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	208,402	5.00
6.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	105,280	6.00
7.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	1,970	7.00
8.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	5,255	8.00
9.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	31,710	9.00
10.00		0.00	0	0	OPERATING ROOM	50.00	0	74,543	10.00
11.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	2,013	11.00
12.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	196,698	12.00
13.00		0.00	0	0	RADIOISOTOPE	56.00	0	918	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	564	14.00
15.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	34,178	15.00
16.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	83,586	16.00
17.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	51,730	17.00
18.00		0.00	0	0	CLINIC	90.00	0	129,128	18.00
19.00		0.00	0	0	ONCOLOGY	90.02	0	100,142	19.00
20.00		0.00	0	0	HBURG URGENT CARE CLINIC	90.04	0	466,095	20.00
21.00		0.00	0	0	EMERGENCY	91.00	0	245,725	21.00
22.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	11,097	22.00
23.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	50,540	23.00
	TOTALS		0	1,810,928	TOTALS		0	1,810,928	
	D - DRUGS RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,485,748	ADMINISTRATIVE & GENERAL	5.00	0	5,717	1.00
2.00	LABORATORY	60.00	0	39	DIETARY	10.00	0	6,376	2.00
3.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	364	3.00
4.00		0.00	0	0	PHARMACY	15.00	0	20,086,850	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	255	5.00
6.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	34	6.00
7.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	42	7.00
8.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	13	8.00
9.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	6	9.00
10.00		0.00	0	0	OPERATING ROOM	50.00	0	250	10.00
11.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	105,443	11.00
12.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	170,477	12.00
13.00		0.00	0	0	RADIOISOTOPE	56.00	0	4	13.00
14.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	939	14.00
15.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	2,981	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	29,085	16.00
17.00		0.00	0	0	CLINIC	90.00	0	10,863	17.00
18.00		0.00	0	0	HBURG URGENT CARE CLINIC	90.04	0	13,643	18.00
19.00		0.00	0	0	EMERGENCY	91.00	0	15,894	19.00
20.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	11,260	20.00
21.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	25,291	21.00
	TOTALS		0	20,485,787	TOTALS		0	20,485,787	
	E - INTERN AND RESIDENT RECLASS								
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	1,297,819	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	1,297,819	1.00
	TOTALS		0	1,297,819	TOTALS		0	1,297,819	
	F - DISABILITY LEAVE RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,294	ADMINISTRATIVE & GENERAL	5.00	46,294	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	2,141	MAINTENANCE & REPAIRS	6.00	2,141	0	2.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 1/25/2024 11:51 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	0	7,234	LAUNDRY & LINEN SERVICE	8.00	7,234	0	3.00
4.00	DIETARY	10.00	0	23,198	DIETARY	10.00	23,198	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	36,705	NURSING ADMINISTRATION	13.00	36,705	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,857	CENTRAL SERVICES & SUPPLY	14.00	10,857	0	6.00
7.00	PHARMACY	15.00	0	16,008	PHARMACY	15.00	16,008	0	7.00
8.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	4,616	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	4,616	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	91,629	ADULTS & PEDIATRICS	30.00	91,629	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	73,614	INTENSIVE CARE UNIT	31.00	73,614	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	21,782	SUBPROVIDER - IPF	40.00	21,782	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	14,241	SUBPROVIDER - IRF	41.00	14,241	0	12.00
13.00	SKILLED NURSING FACILITY	44.00	0	19,273	SKILLED NURSING FACILITY	44.00	19,273	0	13.00
14.00	OPERATING ROOM	50.00	0	56,459	OPERATING ROOM	50.00	56,459	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	46,047	ANESTHESIOLOGY	53.00	46,047	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	68,866	RADIOLOGY-DIAGNOSTIC	54.00	68,866	0	16.00
17.00	LABORATORY	60.00	0	26,593	LABORATORY	60.00	26,593	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	26,131	RESPIRATORY THERAPY	65.00	26,131	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	33,082	PHYSICAL THERAPY	66.00	33,082	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	68,882	ELECTROCARDIOLOGY	69.00	68,882	0	20.00
21.00	RURAL HEALTH CLINIC II	88.01	0	1,018	RURAL HEALTH CLINIC II	88.01	1,018	0	21.00
22.00	CLINIC	90.00	0	10,055	CLINIC	90.00	10,055	0	22.00
23.00	ONCOLOGY	90.02	0	44,231	ONCOLOGY	90.02	44,231	0	23.00
24.00	HBURG URGENT CARE CLINIC	90.04	0	19,264	HBURG URGENT CARE CLINIC	90.04	19,264	0	24.00
25.00	EMERGENCY	91.00	0	67,613	EMERGENCY	91.00	67,613	0	25.00
26.00	AMBULANCE SERVICES	95.00	0	33,872	AMBULANCE SERVICES	95.00	33,872	0	26.00
27.00	HOME HEALTH AGENCY	101.00	0	3,199	HOME HEALTH AGENCY	101.00	3,199	0	27.00
28.00	PHYSICIANS PRIVATE OFFICES	192.00	0	149,692	PHYSICIANS PRIVATE OFFICES	192.00	149,692	0	28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	8,832	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	8,832	0	29.00
30.00	COMMUNITY EDUCATION	194.04	0	1,105	COMMUNITY EDUCATION	194.04	1,105	0	30.00
31.00	VOLUNTEER	194.05	0	9,848	VOLUNTEER	194.05	9,848	0	31.00
	TOTALS		0	1,042,381	TOTALS		1,042,381	0	
	G - PHARMACY RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,738,220	0	PHARMACY	15.00	1,738,220	0	1.00
	TOTALS		1,738,220	0	TOTALS		1,738,220	0	
	H - VOLUNTEER/GUEST SVC								
1.00	OFFSITE COVID SCREENING	194.07	157,393	11,460	ADMINISTRATIVE & GENERAL	5.00	157,393	11,460	1.00
	TOTALS		157,393	11,460	TOTALS		157,393	11,460	
500.00	Grand Total: Increases		4,729,753	25,479,589	Grand Total: Decreases		5,772,134	24,437,208	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 1/25/2024 11:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,188,088	20,585	0	20,585	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	122,498,934	1,528,159	0	1,528,159	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	158,911,560	8,056,630	0	8,056,630	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	292,598,582	9,605,374	0	9,605,374	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	292,598,582	9,605,374	0	9,605,374	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	11,208,673	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	124,027,093	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	166,968,190	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	302,203,956	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	302,203,956	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,325,369	797,020	2,148,337	187,711	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,536,543	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,861,912	797,020	2,148,337	187,711	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,458,437	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,536,543	2.00
3.00	Total (sum of lines 1-2)	0	11,994,980	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	135,235,766	0	135,235,766	0.447498	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	166,968,190	0	166,968,190	0.552502	0	2.00
3.00	Total (sum of lines 1-2)	302,203,956	0	302,203,956	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,275,608	797,020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,539,302	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,814,910	797,020	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	187,711	0	0	7,260,339	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,539,302	2.00
3.00	Total (sum of lines 1-2)	0	187,711	0	0	12,799,641	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,148,337	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-13,516,569			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-22,836	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	66,989,181			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-632,765	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-473,546	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-30,587	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING - NURSING ADMIN	A	-3,856	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	ADVERTISING - SKILLED NURSING	A	-1,750	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	ADVERTISING - CARING HANDS	A	-34	SUBPROVIDER - IPF	40.00	0	33.02
33.03	ADVERTISING - PT	A	-242	PHYSICAL THERAPY	66.00	0	33.03
33.05	ADVERTISING - FRENCH LICK	A	-640	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	ADVERTISING - LOOGOOTEE	A	-119	RURAL HEALTH CLINIC II	88.01	0	33.06
33.08	ADVERTISING - HUNTINGBURG	A	-243	HBURG URGENT CARE CLINIC	90.04	0	33.08
33.09	ADVERTISING - AMBULANCE	A	-1,870	AMBULANCE SERVICES	95.00	0	33.09
33.10	PHYSICIAN RECRUITMENT	A	-7,861	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.10
33.11	MISCELLANEOUS REVENUE - ADMIN	B	-150,954	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MISCELLANEOUS - ENGINEERING	B	-83	MAINTENANCE & REPAIRS	6.00	0	33.12
33.13	MISCELLANEOUS - DIETARY	B	-1,486	DIETARY	10.00	0	33.13
33.15	MISCELLANEOUS - CLINICAL	B	-9,787	NURSING ADMINISTRATION	13.00	0	33.15
33.16	MISCELLANEOUS - STERILE PROC	B	-3,082	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.18	MISCELLANEOUS - REHAB	B	-27,663	SUBPROVIDER - IRF	41.00	0	33.18
33.19	MISCELLANEOUS - RADIOLOGY	B	-391	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	MISCELLANEOUS - LABS	B	-58,790	LABORATORY	60.00	0	33.20
33.21	MISCELLANEOUS - THERAPY	B	-314,976	PHYSICAL THERAPY	66.00	0	33.21
33.26	MISCELLANEOUS - AMBULANCE	B	-232,613	AMBULANCE SERVICES	95.00	0	33.26
33.27	CRNA EXPENSE	A	-728,332	OPERATING ROOM	50.00	0	33.27
33.28	CRNA EXPENSE	A	-2,782,227	ANESTHESIOLOGY	53.00	0	33.28
33.29	I/R START UP COSTS AMORTIZATION	A	2,759	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30	I/R START UP COSTS AMORTIZATION	A	11,370	MAINTENANCE & REPAIRS	6.00	0	33.30
33.31	I/R START UP COSTS AMORTIZATION	A	219,884	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		46,071,555				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/25/2024 11:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3,430,722	4,230,758	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	2,950,239	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	32,213,703	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G	24,748,592	0	4.00
4.01	6.00	MAINTENANCE & REPAIRS	PLANT ENGINEERING	1,039,379	0	4.01
4.02	9.00	HOUSEKEEPING	ENVIRONMENTAL SERVICES	1,668,838	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,566,112	0	4.03
4.04	194.03	MKT/PHY SERVICES	PHYSICIAN SERVICES	3,602,354	0	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			71,219,939	4,230,758	5.00

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

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

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

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

6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00	B		0.00	MEMORIAL HOME O	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 1/25/2024 11:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-800,036	0		1.00
2.00	2,950,239	9		2.00
3.00	32,213,703	0		3.00
4.00	24,748,592	0		4.00
4.01	1,039,379	0		4.01
4.02	1,668,838	0		4.02
4.03	1,566,112	0		4.03
4.04	3,602,354	0		4.04
5.00	66,989,181			5.00

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

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

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

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

6.00	SURGERY CENTER		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2024 11:51 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	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	1,052,816	0	1,052,816	197,500	6,404	1.00
2.00	40.00	SUBPROVIDER - IPF	132,817	132,817	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	4	4	0	179,000	0	3.00
4.00	50.00	OPERATING ROOM	2,041	2,041	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,292,517	1,292,517	0	239,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	4,713,782	4,713,782	0	271,900	0	6.00
7.00	60.00	LABORATORY	150,000	150,000	0	271,900	0	7.00
8.00	65.00	RESPIRATORY THERAPY	1,210	1,210	0	211,500	0	8.00
9.00	66.00	PHYSICAL THERAPY	2,576	2,576	0	211,500	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	550,112	550,112	0	211,500	0	10.00
11.00	90.00	CLINIC	318,162	318,162	0	211,500	0	11.00
12.00	90.04	HBURG URGENT CARE CLINIC	315,456	315,456	0	211,500	0	12.00
13.00	91.00	EMERGENCY	5,591,828	5,591,828	0	211,500	0	13.00
14.00	95.00	AMBULANCE SERVICES	1,320	1,320	0	211,500	0	14.00
200.00			14,124,641	13,071,825	1,052,816		6,404	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	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	608,072	30,404	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	14.00
200.00			608,072	30,404	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	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	608,072	444,744	444,744		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	132,817		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	4		3.00
4.00	50.00	OPERATING ROOM	0	0	0	2,041		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,292,517		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,713,782		6.00
7.00	60.00	LABORATORY	0	0	0	150,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	1,210		8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	2,576		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	550,112		10.00
11.00	90.00	CLINIC	0	0	0	318,162		11.00
12.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	315,456		12.00
13.00	91.00	EMERGENCY	0	0	0	5,591,828		13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	1,320		14.00
200.00			0	608,072	444,744	13,516,569		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,260,339	7,260,339				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,539,302		5,539,302			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,213,703	0	0	32,213,703		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,848,375	190,233	145,139	485,148	28,668,895	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,104,277	6,893	5,259	195,166	5,311,595	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	372,440	22,969	17,524	90,365	503,298	8.00
9.00	00900	HOUSEKEEPING	1,668,838	0	0	0	1,668,838	9.00
10.00	01000	DIETARY	358,946	22,755	17,361	68,820	467,882	10.00
11.00	01100	CAFETERIA	863,338	73,542	56,109	284,856	1,277,845	11.00
13.00	01300	NURSING ADMINISTRATION	1,108,078	15,973	12,187	298,367	1,434,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	493,331	13,319	10,162	97,754	614,566	14.00
15.00	01500	PHARMACY	138,112	41,881	31,954	121,948	333,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,535,525	0	0	0	1,535,525	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,297,819	0	0	0	1,297,819	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,256,390	59,051	45,053	420,161	1,780,655	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,964,950	358,853	273,788	1,783,579	9,381,170	30.00
31.00	03100	INTENSIVE CARE UNIT	3,027,216	164,761	125,705	847,691	4,165,373	31.00
40.00	04000	SUBPROVIDER - IPF	1,383,608	130,161	99,306	438,223	2,051,298	40.00
41.00	04100	SUBPROVIDER - IRF	684,860	67,909	51,811	174,476	979,056	41.00
43.00	04300	NURSERY	723,084	42,610	32,510	197,270	995,474	43.00
44.00	04400	SKILLED NURSING FACILITY	1,584,008	73,851	56,345	429,634	2,143,838	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,160,484	487,761	372,139	1,763,857	16,784,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,446,167	85,221	65,019	394,541	1,990,948	52.00
53.00	05300	ANESTHESIOLOGY	291,260	0	0	1,207,153	1,498,413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,339,668	164,531	125,529	2,296,515	6,926,243	54.00
56.00	05600	RADIOISOTOPE	927,751	11,179	8,529	62,516	1,009,975	56.00
60.00	06000	LABORATORY	8,724,011	79,405	60,582	1,076,136	9,940,134	60.00
65.00	06500	RESPIRATORY THERAPY	2,213,947	29,141	22,233	424,703	2,690,024	65.00
66.00	06600	PHYSICAL THERAPY	2,923,906	70,167	53,534	951,238	3,998,845	66.00
69.00	06900	ELECTROCARDIOLOGY	4,119,413	155,031	118,282	882,556	5,275,282	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	172,709	19,269	14,701	35,771	242,450	69.02
69.03	06903	SLEEP LAB	265,419	22,137	16,890	78,282	382,728	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,810,928	0	0	0	1,810,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,285,095	0	0	0	5,285,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,223,968	0	0	537,673	22,761,641	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	543,940	22,763	17,367	129,600	713,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	670,533	52,514	40,066	180,303	943,416	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	588,900	67,441	51,455	155,666	863,462	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	3,781,090	143,852	109,752	860,578	4,895,272	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,244,032	63,258	48,263	400,067	1,755,620	90.04
90.05	09005	DIABETES MGMT CLINIC	67,602	6,529	4,981	19,800	98,912	90.05
91.00	09100	EMERGENCY	4,938,403	127,356	97,167	3,067,216	8,230,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,814,299	25,639	19,561	886,461	3,745,960	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,507,473	29,775	22,717	695,176	3,255,141	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,487,537	2,947,730	2,248,980	22,039,266	169,710,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,797	9,001	0	20,798	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	37,289,874	1,206,964	920,857	9,550,253	48,967,948	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	865,041	29,173	22,258	259,697	1,176,169	192.01
194.00	07950	LODGE	17,996	342,238	261,112	1,578	622,924	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	148,037	18,017	13,746	42,771	222,571	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.03	07953	MKT/PHY SERVICES	3,922,274	951	725	81,578	4,005,528	194.03
194.04	07954	COMMUNITY EDUCATION	486,708	58,544	44,666	106,912	696,830	194.04
194.05	07955	VOLUNTEER	265,035	0	0	74,245	339,280	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	168,853	0	0	48,685	217,538	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	222,537	0	0	8,718	231,255	194.10
194.11	07961	HOME OFFICE	0	2,644,925	2,017,957	0	4,662,882	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,873,892	7,260,339	5,539,302	32,213,703	230,873,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,668,895					5.00
6.00	00600	MAINTENANCE & REPAIRS	753,083	6,064,678				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,358	19,722	594,378			8.00
9.00	00900	HOUSEKEEPING	236,610	0	0	1,905,448		9.00
10.00	01000	DIETARY	66,337	19,538	4,059	6,159	563,975	10.00
11.00	01100	CAFETERIA	181,174	63,145	0	19,904	0	11.00
13.00	01300	NURSING ADMINISTRATION	203,400	13,715	0	4,323	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,134	11,436	22,343	3,605	0	14.00
15.00	01500	PHARMACY	47,340	35,961	0	11,335	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217,708	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	184,006	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	252,463	50,703	0	15,982	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,330,072	308,121	111,184	97,124	220,956	30.00
31.00	03100	INTENSIVE CARE UNIT	590,571	141,468	35,270	44,593	101,205	31.00
40.00	04000	SUBPROVIDER - IPF	290,835	111,760	8,084	35,228	30,084	40.00
41.00	04100	SUBPROVIDER - IRF	138,812	58,308	9,590	18,380	32,170	41.00
43.00	04300	NURSERY	141,139	36,586	295	11,533	54,171	43.00
44.00	04400	SKILLED NURSING FACILITY	303,955	63,411	25,466	19,988	125,389	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,379,686	418,806	90,962	132,013	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	282,279	73,173	29,192	23,065	0	52.00
53.00	05300	ANESTHESIOLOGY	212,446	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,010	141,271	77,569	44,530	0	54.00
56.00	05600	RADIOISOTOPE	143,195	9,599	0	3,026	0	56.00
60.00	06000	LABORATORY	1,409,322	68,180	1,930	21,491	0	60.00
65.00	06500	RESPIRATORY THERAPY	381,394	25,021	0	7,887	0	65.00
66.00	06600	PHYSICAL THERAPY	566,960	60,247	21,999	18,991	0	66.00
69.00	06900	ELECTROCARDIOLOGY	747,935	133,114	37,765	41,959	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	34,375	16,545	520	5,215	0	69.02
69.03	06903	SLEEP LAB	54,264	19,008	3,834	5,991	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,755	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	749,326	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,227,168	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	101,185	19,545	0	6,161	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	133,758	45,090	0	14,213	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	122,423	57,907	1,312	18,253	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	694,057	123,515	15,666	38,934	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	248,914	54,315	1,641	17,121	0	90.04
90.05	09005	DIABETES MGMT CLINIC	14,024	5,606	0	1,767	0	90.05
91.00	09100	EMERGENCY	1,166,878	109,351	84,966	34,469	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	531,106	22,014	3,436	6,939	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	461,517	25,566	0	8,059	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,996,974	2,361,747	587,083	738,238	563,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,949	10,130	0	3,193	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,942,792	1,036,334	7,295	326,666	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	166,758	25,049	0	7,896	0	192.01
194.00	07950	LODGE	88,319	293,855	0	92,627	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	31,556	15,470	0	4,876	0	194.02
194.03	07953	MKT/PHY SERVICES	567,908	816	0	257	0	194.03
194.04	07954	COMMUNITY EDUCATION	98,797	50,267	0	15,845	0	194.04
194.05	07955	VOLUNTEER	48,103	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	30,843	0	0	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	32,788	0	0	0	0	194.10
194.11	07961	HOME OFFICE	661,108	2,271,010	0	715,850	0	194.11
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)	28,668,895	6,064,678	594,378	1,905,448	563,975	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,542,068					11.00
13.00	01300	NURSING ADMINISTRATION	18,407	1,674,450				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,992	0	750,076			14.00
15.00	01500	PHARMACY	4,686	0	3,041	436,258		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,753,233	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,173	0	134	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,664	739,802	21,557	0	24,374	30.00
31.00	03100	INTENSIVE CARE UNIT	61,619	415,688	5,525	0	17,041	31.00
40.00	04000	SUBPROVIDER - IPF	21,730	146,591	628	0	3,757	40.00
41.00	04100	SUBPROVIDER - IRF	11,985	80,854	333	0	3,354	41.00
43.00	04300	NURSERY	11,618	78,374	0	0	3,665	43.00
44.00	04400	SKILLED NURSING FACILITY	31,595	213,141	1,801	0	3,208	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,018	0	224,434	0	188,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,235	0	0	0	5,677	52.00
53.00	05300	ANESTHESIOLOGY	26,597	0	13,932	0	12,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,723	0	14,466	0	238,268	54.00
56.00	05600	RADIOISOTOPE	3,339	0	205	0	32,734	56.00
60.00	06000	LABORATORY	67,220	0	191,350	0	169,738	60.00
65.00	06500	RESPIRATORY THERAPY	32,174	0	42,791	0	18,471	65.00
66.00	06600	PHYSICAL THERAPY	64,084	0	2,240	0	33,938	66.00
69.00	06900	ELECTROCARDIOLOGY	45,311	0	43,602	0	105,480	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,708	0	379	0	3,440	69.02
69.03	06903	SLEEP LAB	6,549	0	616	0	4,811	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	113,121	0	27,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	50,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,585	0	0	436,258	275,009	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,734	0	884	0	2,535	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,987	0	869	0	2,261	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,322	0	2,468	0	9,059	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	67,764	0	8,539	0	68,875	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	23,815	0	4,913	0	14,179	90.04
90.05	09005	DIABETES MGMT CLINIC	1,449	0	129	0	398	90.05
91.00	09100	EMERGENCY	96,735	0	12,006	0	161,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	70,605	0	2,999	0	18,836	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	51,233	0	1,589	0	9,783	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,106,656	1,674,450	714,551	436,258	1,508,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	385,266	0	31,781	0	239,477	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	18,945	0	133	0	3,805	192.01
194.00	07950	LODGE	183	0	16	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,917	0	43	0	0	194.02
194.03	07953	MKT/PHY SERVICES	3,070	0	23	0	1,121	194.03
194.04	07954	COMMUNITY EDUCATION	12,917	0	1,719	0	0	194.04
194.05	07955	VOLUNTEER	4,997	0	62	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.07	07957	OFFSITE COVID SCREENING	5,706	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	1,411	0	1,748	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,542,068	1,674,450	750,076	436,258	1,753,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,481,825					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		2,109,110				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	399,544	568,679	13,312,247	-968,223	12,344,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,578,353	0	5,578,353	31.00
40.00	04000	SUBPROVIDER - IPF	30,734	43,745	2,774,474	-74,479	2,699,995	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,332,842	0	1,332,842	41.00
43.00	04300	NURSERY	0	0	1,332,855	0	1,332,855	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,931,792	0	2,931,792	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	161,354	229,659	20,711,229	-391,013	20,320,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,427,569	0	2,427,569	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,764,167	0	1,764,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	8,491,080	0	8,491,080	54.00
56.00	05600	RADIOISOTOPE	0	0	1,202,073	0	1,202,073	56.00
60.00	06000	LABORATORY	0	0	11,869,365	0	11,869,365	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,197,762	0	3,197,762	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,767,304	0	4,767,304	66.00
69.00	06900	ELECTROCARDIOLOGY	46,101	65,617	6,542,166	-111,718	6,430,448	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	46,101	65,617	417,350	-111,718	305,632	69.02
69.03	06903	SLEEP LAB	0	0	477,801	0	477,801	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,208,002	0	2,208,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,084,951	0	6,084,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	26,733,661	0	26,733,661	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	852,714	0	852,714	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,781	12,498	1,170,873	-21,279	1,149,594	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	1,086,206	0	1,086,206	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	4,391	6,249	5,923,262	-10,640	5,912,622	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	60,371	85,927	2,266,816	-146,298	2,120,518	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	122,285	0	122,285	90.05
91.00	09100	EMERGENCY	60,371	85,927	10,042,221	-146,298	9,895,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	4,401,895	0	4,401,895	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,812,888	0	3,812,888	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	817,748	1,163,918	153,836,203	-1,981,666	151,854,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	37,070	0	37,070	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	401,739	571,801	58,911,099	-973,540	57,937,559	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,398,755	0	1,398,755	192.01
194.00	07950	LODGE	0	0	1,097,924	0	1,097,924	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	277,433	0	277,433	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
194.03	07953	MKT/PHY SERVICES	0	0	4,578,723	0	4,578,723	194.03
194.04	07954	COMMUNITY EDUCATION	237,092	337,458	1,450,925	-574,550	876,375	194.04
194.05	07955	VOLUNTEER	0	0	392,442	0	392,442	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	254,087	0	254,087	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	267,202	0	267,202	194.10
194.11	07961	HOME OFFICE	25,246	35,933	8,372,029	-61,179	8,310,850	194.11
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,481,825	2,109,110	230,873,892	-3,590,935	227,282,957	202.00

COST ALLOCATION STATISTICS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet Non-CMS W | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	PATIENT DA YS	10.00
11.00	CAFETERIA	4	HOURS	11.00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	8	REVENUE	16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	9	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	9	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	190,233	145,139	335,372	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,893	5,259	12,152	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,969	17,524	40,493	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	22,755	17,361	40,116	0	10.00
11.00	01100	CAFETERIA	0	73,542	56,109	129,651	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,973	12,187	28,160	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,319	10,162	23,481	0	14.00
15.00	01500	PHARMACY	0	41,881	31,954	73,835	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	59,051	45,053	104,104	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	358,853	273,788	632,641	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	164,761	125,705	290,466	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	130,161	99,306	229,467	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	67,909	51,811	119,720	0	41.00
43.00	04300	NURSERY	0	42,610	32,510	75,120	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	73,851	56,345	130,196	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	487,761	372,139	859,900	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	85,221	65,019	150,240	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	164,531	125,529	290,060	0	54.00
56.00	05600	RADIOISOTOPE	0	11,179	8,529	19,708	0	56.00
60.00	06000	LABORATORY	0	79,405	60,582	139,987	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,141	22,233	51,374	0	65.00
66.00	06600	PHYSICAL THERAPY	0	70,167	53,534	123,701	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	155,031	118,282	273,313	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	19,269	14,701	33,970	0	69.02
69.03	06903	SLEEP LAB	0	22,137	16,890	39,027	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	22,763	17,367	40,130	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	52,514	40,066	92,580	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	67,441	51,455	118,896	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	143,852	109,752	253,604	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	63,258	48,263	111,521	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	6,529	4,981	11,510	0	90.05
91.00	09100	EMERGENCY	0	127,356	97,167	224,523	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	25,639	19,561	45,200	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	29,775	22,717	52,492	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,947,730	2,248,980	5,196,710	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,797	9,001	20,798	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,206,964	920,857	2,127,821	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,173	22,258	51,431	0	192.01
194.00	07950	LODGE	0	342,238	261,112	603,350	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	18,017	13,746	31,763	0	194.02
194.03	07953	MKT/PHY SERVICES	0	951	725	1,676	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.04	07954	COMMUNITY EDUCATION	0	58,544	44,666	103,210	0	194.04
194.05	07955	VOLUNTEER	0	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	0	194.10
194.11	07961	HOME OFFICE	0	2,644,925	2,017,957	4,662,882	0	194.11
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,260,339	5,539,302	12,799,641	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	335,372					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,812	20,964				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	835	68	41,396			8.00
9.00	00900	HOUSEKEEPING	2,769	0	0	2,769		9.00
10.00	01000	DIETARY	776	68	283	9	41,252	10.00
11.00	01100	CAFETERIA	2,120	218	0	29	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,380	47	0	6	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,020	40	1,556	5	0	14.00
15.00	01500	PHARMACY	554	124	0	16	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,547	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,153	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,954	175	0	23	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,563	1,065	7,745	141	16,161	30.00
31.00	03100	INTENSIVE CARE UNIT	6,910	489	2,456	65	7,403	31.00
40.00	04000	SUBPROVIDER - IPF	3,403	386	563	51	2,201	40.00
41.00	04100	SUBPROVIDER - IRF	1,624	202	668	27	2,353	41.00
43.00	04300	NURSERY	1,651	126	21	17	3,962	43.00
44.00	04400	SKILLED NURSING FACILITY	3,557	219	1,774	29	9,172	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,845	1,448	6,335	192	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,303	253	2,033	34	0	52.00
53.00	05300	ANESTHESIOLOGY	2,486	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,491	488	5,402	65	0	54.00
56.00	05600	RADIOISOTOPE	1,676	33	0	4	0	56.00
60.00	06000	LABORATORY	16,491	236	134	31	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,463	86	0	11	0	65.00
66.00	06600	PHYSICAL THERAPY	6,634	208	1,532	28	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,752	460	2,630	61	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	402	57	36	8	0	69.02
69.03	06903	SLEEP LAB	635	66	267	9	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,004	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,768	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,762	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,184	68	0	9	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,565	156	0	21	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,432	200	91	27	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	8,121	427	1,091	57	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,913	188	114	25	0	90.04
90.05	09005	DIABETES MGMT CLINIC	164	19	0	3	0	90.05
91.00	09100	EMERGENCY	13,654	378	5,918	50	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,215	76	239	10	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	5,400	88	0	12	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,988	8,162	40,888	1,075	41,252	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	35	35	0	5	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	81,151	3,582	508	475	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,951	87	0	11	0	192.01
194.00	07950	LODGE	1,033	1,016	0	135	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	369	53	0	7	0	194.02
194.03	07953	MKT/PHY SERVICES	6,645	3	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	1,156	174	0	23	0	194.04
194.05	07955	VOLUNTEER	563	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	361	0	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	384	0	0	0	0	194.10
194.11	07961	HOME OFFICE	7,736	7,852	0	1,038	0	194.11
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)	335,372	20,964	41,396	2,769	41,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	132,018					11.00
13.00	01300	NURSING ADMINISTRATION	1,576	32,169				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	941	0	27,043			14.00
15.00	01500	PHARMACY	401	0	110	75,040		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,547	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	785	0	5	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,388	14,213	777	0	34	30.00
31.00	03100	INTENSIVE CARE UNIT	5,275	7,986	199	0	23	31.00
40.00	04000	SUBPROVIDER - IPF	1,860	2,816	23	0	5	40.00
41.00	04100	SUBPROVIDER - IRF	1,026	1,553	12	0	5	41.00
43.00	04300	NURSERY	995	1,506	0	0	5	43.00
44.00	04400	SKILLED NURSING FACILITY	2,705	4,095	65	0	4	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,734	0	8,091	0	259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,989	0	0	0	8	52.00
53.00	05300	ANESTHESIOLOGY	2,277	0	502	0	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,712	0	522	0	328	54.00
56.00	05600	RADIOISOTOPE	286	0	7	0	45	56.00
60.00	06000	LABORATORY	5,755	0	6,898	0	234	60.00
65.00	06500	RESPIRATORY THERAPY	2,754	0	1,543	0	25	65.00
66.00	06600	PHYSICAL THERAPY	5,486	0	81	0	47	66.00
69.00	06900	ELECTROCARDIOLOGY	3,879	0	1,572	0	145	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	232	0	14	0	5	69.02
69.03	06903	SLEEP LAB	561	0	22	0	7	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,078	0	37	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	70	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,875	0	0	75,040	511	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	748	0	32	0	3	88.00
88.01	08801	RURAL HEALTH CLINIC II	855	0	31	0	3	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	969	0	89	0	12	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	5,801	0	308	0	95	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,039	0	177	0	20	90.04
90.05	09005	DIABETES MGMT CLINIC	124	0	5	0	1	90.05
91.00	09100	EMERGENCY	8,282	0	433	0	222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,045	0	108	0	26	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	4,386	0	57	0	13	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,741	32,169	25,761	75,040	2,210	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	32,983	0	1,146	0	330	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,622	0	5	0	5	192.01
194.00	07950	LODGE	16	0	1	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	250	0	2	0	0	194.02
194.03	07953	MKT/PHY SERVICES	263	0	1	0	2	194.03
194.04	07954	COMMUNITY EDUCATION	1,106	0	62	0	0	194.04
194.05	07955	VOLUNTEER	428	0	2	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.07	07957	OFFSITE COVID SCREENING	488	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	121	0	63	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
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)	132,018	32,169	27,043	75,040	2,547	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,153					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		108,046				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			697,728	0	697,728	30.00
31.00	03100	INTENSIVE CARE UNIT			321,272	0	321,272	31.00
40.00	04000	SUBPROVIDER - IPF			240,775	0	240,775	40.00
41.00	04100	SUBPROVIDER - IRF			127,190	0	127,190	41.00
43.00	04300	NURSERY			83,403	0	83,403	43.00
44.00	04400	SKILLED NURSING FACILITY			151,816	0	151,816	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			912,804	0	912,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			157,860	0	157,860	52.00
53.00	05300	ANESTHESIOLOGY			5,283	0	5,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			314,068	0	314,068	54.00
56.00	05600	RADIOISOTOPE			21,759	0	21,759	56.00
60.00	06000	LABORATORY			169,766	0	169,766	60.00
65.00	06500	RESPIRATORY THERAPY			60,256	0	60,256	65.00
66.00	06600	PHYSICAL THERAPY			137,717	0	137,717	66.00
69.00	06900	ELECTROCARDIOLOGY			290,812	0	290,812	69.00
69.01	06901	PULMONARY			0	0	0	69.01
69.02	06902	CARDIOPULMONARY			34,724	0	34,724	69.02
69.03	06903	SLEEP LAB			40,594	0	40,594	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY			0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			7,119	0	7,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			8,838	0	8,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			116,188	0	116,188	73.00
74.00	07400	RENAL DIALYSIS			0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION			0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			42,174	0	42,174	88.00
88.01	08801	RURAL HEALTH CLINIC II			95,211	0	95,211	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90.00	09000	CLINIC			121,716	0	121,716	90.00
90.01	09001	IMED			0	0	0	90.01
90.02	09002	ONCOLOGY			269,504	0	269,504	90.02
90.03	09003	OUTPATIENT CENTER			0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC			116,997	0	116,997	90.04
90.05	09005	DIABETES MGMT CLINIC			11,826	0	11,826	90.05
91.00	09100	EMERGENCY			253,460	0	253,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			57,919	0	57,919	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY			62,448	0	62,448	101.00
102.00	10200	OPIOID TREATMENT PROGRAM			0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,931,227	0	4,931,227	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN			20,873	0	20,873	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES			2,247,996	0	2,247,996	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			55,112	0	55,112	192.01
194.00	07950	LODGE			605,551	0	605,551	194.00
194.01	07951	OTHER NRCC			0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION			32,444	0	32,444	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
194.03	07953	MKT/PHY SERVICES			8,590	0	8,590	194.03
194.04	07954	COMMUNITY EDUCATION			105,731	0	105,731	194.04
194.05	07955	VOLUNTEER			993	0	993	194.05
194.06	07956	MAB			0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING			849	0	849	194.07
194.08	07958	PUBLIC RELATIONS			0	0	0	194.08
194.09	07959	UNUSED SPACE			0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS			568	0	568	194.10
194.11	07961	HOME OFFICE			4,679,508	0	4,679,508	194.11
200.00		Cross Foot Adjustments	2,153	108,046	110,199	0	110,199	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,153	108,046	12,799,641	0	12,799,641	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	916,352					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		916,352				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	104,142,131			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,010	24,010	1,568,413	-28,668,895	202,204,997	5.00
6.00	00600	MAINTENANCE & REPAIRS	870	870	630,942	0	5,311,595	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	292,136	0	503,298	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,668,838	9.00
10.00	01000	DIETARY	2,872	2,872	222,484	0	467,882	10.00
11.00	01100	CAFETERIA	9,282	9,282	920,900	0	1,277,845	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	2,016	964,577	0	1,434,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	316,026	0	614,566	14.00
15.00	01500	PHARMACY	5,286	5,286	394,241	0	333,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,535,525	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,297,819	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,453	7,453	1,358,320	0	1,780,655	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	45,292	5,766,054	0	9,381,170	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	2,740,463	0	4,165,373	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	1,416,711	0	2,051,298	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	564,057	0	979,056	41.00
43.00	04300	NURSERY	5,378	5,378	637,747	0	995,474	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	9,321	1,388,944	0	2,143,838	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,562	61,562	5,702,295	0	16,784,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	10,756	1,275,493	0	1,990,948	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,902,552	0	1,498,413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	7,424,304	0	6,926,243	54.00
56.00	05600	RADIOISOTOPE	1,411	1,411	202,106	0	1,009,975	56.00
60.00	06000	LABORATORY	10,022	10,022	3,478,992	0	9,940,134	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	3,678	1,373,005	0	2,690,024	65.00
66.00	06600	PHYSICAL THERAPY	8,856	8,856	3,075,216	0	3,998,845	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	19,567	2,853,178	0	5,275,282	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	2,432	115,643	0	242,450	69.02
69.03	06903	SLEEP LAB	2,794	2,794	253,074	0	382,728	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,810,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,285,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,738,220	0	22,761,641	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	2,873	418,977	0	713,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	582,893	0	943,416	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	8,512	503,247	0	863,462	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,156	18,156	2,782,126	0	4,895,272	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	7,984	1,293,360	0	1,755,620	90.04
90.05	09005	DIABETES MGMT CLINIC	824	824	64,012	0	98,912	90.05
91.00	09100	EMERGENCY	16,074	16,074	9,915,867	0	8,230,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	3,236	2,865,800	0	3,745,960	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	3,758	2,247,405	0	3,255,141	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,043	372,043	71,249,780	-28,668,895	141,041,274	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,489	1,489	0	0	20,798	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	152,335	152,335	30,874,451	0	48,967,948	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	3,682	839,564	0	1,176,169	192.01
194.00	07950	LODGE	43,195	43,195	5,100	0	622,924	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,274	2,274	138,271	0	222,571	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.03	07953	MKT/PHY SERVICES	120	120	263,730	0	4,005,528	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	7,389	345,632	0	696,830	194.04
194.05	07955	VOLUNTEER	0	0	240,025	0	339,280	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	157,393	0	217,538	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	28,185	0	231,255	194.10
194.11	07961	HOME OFFICE	333,825	333,825	0	0	4,662,882	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,260,339	5,539,302	32,213,703		28,668,895	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.923090	6.044950	0.309324		0.141781	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		335,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.001659	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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	891,472					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	806,995				8.00
9.00	00900	HOUSEKEEPING	0	0	888,573			9.00
10.00	01000	DIETARY	2,872	5,511	2,872	17,303		10.00
11.00	01100	CAFETERIA	9,282	0	9,282	0	1,971,630	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	0	2,016	0	23,534	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	30,335	1,681	0	14,054	14.00
15.00	01500	PHARMACY	5,286	0	5,286	0	5,991	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,453	0	7,453	0	11,728	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	150,958	45,292	6,779	140,212	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	47,886	20,795	3,105	78,784	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	10,976	16,428	923	27,783	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	13,020	8,571	987	15,324	41.00
43.00	04300	NURSERY	5,378	400	5,378	1,662	14,854	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	34,575	9,321	3,847	40,396	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,562	123,501	61,562	0	130,437	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	39,635	10,756	0	29,707	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	34,006	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	105,316	20,766	0	85,309	54.00
56.00	05600	RADIOISOTOPE	1,411	0	1,411	0	4,269	56.00
60.00	06000	LABORATORY	10,022	2,620	10,022	0	85,945	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	0	3,678	0	41,136	65.00
66.00	06600	PHYSICAL THERAPY	8,856	29,868	8,856	0	81,935	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	51,274	19,567	0	57,933	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	706	2,432	0	3,462	69.02
69.03	06903	SLEEP LAB	2,794	5,205	2,794	0	8,373	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	42,941	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	0	2,873	0	11,167	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	12,769	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	1,781	8,512	0	14,476	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,156	21,270	18,156	0	86,640	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	2,228	7,984	0	30,449	90.04
90.05	09005	DIABETES MGMT CLINIC	824	0	824	0	1,852	90.05
91.00	09100	EMERGENCY	16,074	115,360	16,074	0	123,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	4,665	3,236	0	90,273	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	0	3,758	0	65,504	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,163	797,090	344,264	17,303	1,414,925	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	152,335	9,905	152,335	0	492,591	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	0	3,682	0	24,222	192.01
194.00	07950	LODGE	43,195	0	43,195	0	234	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,274	0	2,274	0	3,730	194.02
194.03	07953	MKT/PHY SERVICES	120	0	120	0	3,925	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	0	7,389	0	16,515	194.04
194.05	07955	VOLUNTEER	0	0	0	0	6,389	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	7,295	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	1,804	194.10
194.11	07961	HOME OFFICE	333,825	0	333,825	0	0	194.11
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)	6,064,678	594,378	1,905,448	563,975	1,542,068	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.802993	0.736532	2.144391	32.594059	0.782128	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,964	41,396	2,769	41,252	132,018	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.023516	0.051296	0.003116	2.384095	0.066959	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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	317,353					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,007,827				14.00
15.00	01500	PHARMACY	0	48,685	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	805,745,072		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,350	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,150	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,212	345,104	0	11,201,138	364	30.00
31.00	03100	INTENSIVE CARE UNIT	78,784	88,453	0	7,831,258	0	31.00
40.00	04000	SUBPROVIDER - IPF	27,783	10,053	0	1,726,350	28	40.00
41.00	04100	SUBPROVIDER - IRF	15,324	5,325	0	1,541,337	0	41.00
43.00	04300	NURSERY	14,854	0	0	1,684,388	0	43.00
44.00	04400	SKILLED NURSING FACILITY	40,396	28,835	0	1,474,312	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,592,927	0	86,422,916	147	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,609,143	0	52.00
53.00	05300	ANESTHESIOLOGY	0	223,035	0	5,872,879	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,580	0	109,498,391	0	54.00
56.00	05600	RADIOISOTOPE	0	3,283	0	15,043,157	0	56.00
60.00	06000	LABORATORY	0	3,063,270	0	78,004,560	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	685,028	0	8,488,726	0	65.00
66.00	06600	PHYSICAL THERAPY	0	35,856	0	15,596,619	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	698,017	0	48,474,481	42	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	6,070	0	1,580,774	42	69.02
69.03	06903	SLEEP LAB	0	9,866	0	2,211,029	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,810,928	0	12,499,226	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,221,312	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	126,412,450	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,150	0	1,165,084	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	13,910	0	1,039,221	8	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	39,512	0	4,163,278	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	136,697	0	31,652,135	4	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	78,657	0	6,516,128	55	90.04
90.05	09005	DIABETES MGMT CLINIC	0	2,072	0	182,957	0	90.05
91.00	09100	EMERGENCY	0	192,203	0	74,161,916	55	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	48,005	0	8,656,415	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	25,437	0	4,495,701	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	317,353	11,439,108	100	693,427,281	745	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	508,770	0	110,053,725	366	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,135	0	1,748,819	0	192.01
194.00	07950	LODGE	0	251	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	687	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
194.03	07953	MKT/PHY SERVICES	0	370	0	515,247	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	27,517	0	0	216	194.04
194.05	07955	VOLUNTEER	0	999	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	27,990	0	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	23	194.11
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)	1,674,450	750,076	436,258	1,753,233	1,481,825	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.276301	0.062466	4,362.580000	0.002176	1,097.648148	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,169	27,043	75,040	2,547	2,153	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.101367	0.002252	750.400000	0.000003	1.594815	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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,350		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	364		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
40.00	04000	SUBPROVIDER - IPF	28		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	147		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	42		69.00
69.01	06901	PULMONARY	0		69.01
69.02	06902	CARDIOPULMONARY	42		69.02
69.03	06903	SLEEP LAB	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	8		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	0		90.00
90.01	09001	IMED	0		90.01
90.02	09002	ONCOLOGY	4		90.02
90.03	09003	OUTPATIENT CENTER	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	55		90.04
90.05	09005	DIABETES MGMT CLINIC	0		90.05
91.00	09100	EMERGENCY	55		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	745		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	366		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		192.01
194.00	07950	LODGE	0		194.00
194.01	07951	OTHER NRCC	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0		194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/25/2024 11:51 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)					
			22.00					
194.03	07953	MKT/PHY SERVICES	0					194.03
194.04	07954	COMMUNITY EDUCATION	216					194.04
194.05	07955	VOLUNTEER	0					194.05
194.06	07956	MAB	0					194.06
194.07	07957	OFFSITE COVID SCREENING	0					194.07
194.08	07958	PUBLIC RELATIONS	0					194.08
194.09	07959	UNUSED SPACE	0					194.09
194.10	07960	EMERGENCY PREPAREDNESS	0					194.10
194.11	07961	HOME OFFICE	23					194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,109,110					202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,562.303704					203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,046					204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	80.034074					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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,344,024		12,344,024	0	12,344,024	30.00
31.00	03100	INTENSIVE CARE UNIT	5,578,353		5,578,353	0	5,578,353	31.00
40.00	04000	SUBPROVIDER - IPF	2,699,995		2,699,995	0	2,699,995	40.00
41.00	04100	SUBPROVIDER - IRF	1,332,842		1,332,842	0	1,332,842	41.00
43.00	04300	NURSERY	1,332,855		1,332,855	0	1,332,855	43.00
44.00	04400	SKILLED NURSING FACILITY	2,931,792		2,931,792	0	2,931,792	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,320,216		20,320,216	0	20,320,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,427,569		2,427,569	0	2,427,569	52.00
53.00	05300	ANESTHESIOLOGY	1,764,167		1,764,167	0	1,764,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,491,080		8,491,080	0	8,491,080	54.00
56.00	05600	RADIOISOTOPE	1,202,073		1,202,073	0	1,202,073	56.00
60.00	06000	LABORATORY	11,869,365		11,869,365	0	11,869,365	60.00
65.00	06500	RESPIRATORY THERAPY	3,197,762	0	3,197,762	0	3,197,762	65.00
66.00	06600	PHYSICAL THERAPY	4,767,304	0	4,767,304	0	4,767,304	66.00
69.00	06900	ELECTROCARDIOLOGY	6,430,448		6,430,448	0	6,430,448	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	305,632		305,632	0	305,632	69.02
69.03	06903	SLEEP LAB	477,801		477,801	0	477,801	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,208,002		2,208,002	0	2,208,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,084,951		6,084,951	0	6,084,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,733,661		26,733,661	0	26,733,661	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	852,714		852,714	0	852,714	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,149,594		1,149,594	0	1,149,594	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,086,206		1,086,206	0	1,086,206	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,912,622		5,912,622	0	5,912,622	90.02
90.03	09003	OUTPATIENT CENTER	0		0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,120,518		2,120,518	0	2,120,518	90.04
90.05	09005	DIABETES MGMT CLINIC	122,285		122,285	0	122,285	90.05
91.00	09100	EMERGENCY	9,895,923		9,895,923	0	9,895,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,424,249		4,424,249		4,424,249	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,401,895		4,401,895	0	4,401,895	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,812,888		3,812,888		3,812,888	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	156,278,786	0	156,278,786	0	156,278,786	200.00
201.00		Less Observation Beds	4,424,249		4,424,249		4,424,249	201.00
202.00		Total (see instructions)	151,854,537	0	151,854,537	0	151,854,537	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,201,138		11,201,138			30.00
31.00	03100	INTENSIVE CARE UNIT	7,831,258		7,831,258			31.00
40.00	04000	SUBPROVIDER - IPF	1,726,350		1,726,350			40.00
41.00	04100	SUBPROVIDER - IRF	1,541,337		1,541,337			41.00
43.00	04300	NURSERY	1,684,388		1,684,388			43.00
44.00	04400	SKILLED NURSING FACILITY	1,474,312		1,474,312			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,457,539	76,965,377	86,422,916	0.235125	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,576,287	32,856	2,609,143	0.930409	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,408,558	4,464,321	5,872,879	0.300392	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,678,299	97,820,092	109,498,391	0.077545	0.000000	54.00
56.00	05600	RADIOISOTOPE	313,780	14,729,377	15,043,157	0.079908	0.000000	56.00
60.00	06000	LABORATORY	11,475,724	66,528,836	78,004,560	0.152162	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,992,103	6,496,623	8,488,726	0.376707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,610,688	8,985,931	15,596,619	0.305663	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	14,909,951	33,564,530	48,474,481	0.132656	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	3,742	1,577,032	1,580,774	0.193343	0.000000	69.02
69.03	06903	SLEEP LAB	0	2,211,029	2,211,029	0.216099	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,502,924	9,996,302	12,499,226	0.176651	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,985,327	16,235,985	23,221,312	0.262042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,901,146	103,511,304	126,412,450	0.211480	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,165,084	1,165,084			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,039,221	1,039,221			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	92,293	4,070,985	4,163,278	0.260902	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	149,922	31,502,213	31,652,135	0.186800	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	17,313	6,498,815	6,516,128	0.325426	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	408	182,549	182,957	0.668381	0.000000	90.05
91.00	09100	EMERGENCY	10,320,476	63,841,440	74,161,916	0.133437	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,231,555	8,848,255	10,079,810	0.438922	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,994	8,651,421	8,656,415	0.508512	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	4,495,701	4,495,701			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	130,091,812	573,415,279	703,507,091			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	130,091,812	573,415,279	703,507,091			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.235125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	54.00
56.00	05600	RADIOISOTOPE	0.079908	56.00
60.00	06000	LABORATORY	0.152162	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.193343	69.02
69.03	06903	SLEEP LAB	0.216099	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.260902	90.00
90.01	09001	IMED	0.000000	90.01
90.02	09002	ONCOLOGY	0.186800	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	90.05
91.00	09100	EMERGENCY	0.133437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.508512	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 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	12,344,024		12,344,024	0	12,344,024	30.00
31.00	03100	INTENSIVE CARE UNIT	5,578,353		5,578,353	0	5,578,353	31.00
40.00	04000	SUBPROVIDER - IPF	2,699,995		2,699,995	0	2,699,995	40.00
41.00	04100	SUBPROVIDER - IRF	1,332,842		1,332,842	0	1,332,842	41.00
43.00	04300	NURSERY	1,332,855		1,332,855	0	1,332,855	43.00
44.00	04400	SKILLED NURSING FACILITY	2,931,792		2,931,792	0	2,931,792	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,320,216		20,320,216	0	20,320,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,427,569		2,427,569	0	2,427,569	52.00
53.00	05300	ANESTHESIOLOGY	1,764,167		1,764,167	0	1,764,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,491,080		8,491,080	0	8,491,080	54.00
56.00	05600	RADIOISOTOPE	1,202,073		1,202,073	0	1,202,073	56.00
60.00	06000	LABORATORY	11,869,365		11,869,365	0	11,869,365	60.00
65.00	06500	RESPIRATORY THERAPY	3,197,762	0	3,197,762	0	3,197,762	65.00
66.00	06600	PHYSICAL THERAPY	4,767,304	0	4,767,304	0	4,767,304	66.00
69.00	06900	ELECTROCARDIOLOGY	6,430,448		6,430,448	0	6,430,448	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	305,632		305,632	0	305,632	69.02
69.03	06903	SLEEP LAB	477,801		477,801	0	477,801	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,208,002		2,208,002	0	2,208,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,084,951		6,084,951	0	6,084,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,733,661		26,733,661	0	26,733,661	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	852,714		852,714	0	852,714	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,149,594		1,149,594	0	1,149,594	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,086,206		1,086,206	0	1,086,206	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,912,622		5,912,622	0	5,912,622	90.02
90.03	09003	OUTPATIENT CENTER	0		0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,120,518		2,120,518	0	2,120,518	90.04
90.05	09005	DIABETES MGMT CLINIC	122,285		122,285	0	122,285	90.05
91.00	09100	EMERGENCY	9,895,923		9,895,923	0	9,895,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,424,249		4,424,249		4,424,249	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,401,895		4,401,895	0	4,401,895	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,812,888		3,812,888		3,812,888	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	156,278,786	0	156,278,786	0	156,278,786	200.00
201.00		Less Observation Beds	4,424,249		4,424,249		4,424,249	201.00
202.00		Total (see instructions)	151,854,537	0	151,854,537	0	151,854,537	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 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	11,201,138		11,201,138			30.00
31.00	03100	INTENSIVE CARE UNIT	7,831,258		7,831,258			31.00
40.00	04000	SUBPROVIDER - IPF	1,726,350		1,726,350			40.00
41.00	04100	SUBPROVIDER - IRF	1,541,337		1,541,337			41.00
43.00	04300	NURSERY	1,684,388		1,684,388			43.00
44.00	04400	SKILLED NURSING FACILITY	1,474,312		1,474,312			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,457,539	76,965,377	86,422,916	0.235125	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,576,287	32,856	2,609,143	0.930409	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,408,558	4,464,321	5,872,879	0.300392	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,678,299	97,820,092	109,498,391	0.077545	0.000000	54.00
56.00	05600	RADIOISOTOPE	313,780	14,729,377	15,043,157	0.079908	0.000000	56.00
60.00	06000	LABORATORY	11,475,724	66,528,836	78,004,560	0.152162	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,992,103	6,496,623	8,488,726	0.376707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,610,688	8,985,931	15,596,619	0.305663	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	14,909,951	33,564,530	48,474,481	0.132656	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	3,742	1,577,032	1,580,774	0.193343	0.000000	69.02
69.03	06903	SLEEP LAB	0	2,211,029	2,211,029	0.216099	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,502,924	9,996,302	12,499,226	0.176651	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,985,327	16,235,985	23,221,312	0.262042	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,901,146	103,511,304	126,412,450	0.211480	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,165,084	1,165,084	0.731891	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,039,221	1,039,221	1.106207	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	92,293	4,070,985	4,163,278	0.260902	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	149,922	31,502,213	31,652,135	0.186800	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	17,313	6,498,815	6,516,128	0.325426	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	408	182,549	182,957	0.668381	0.000000	90.05
91.00	09100	EMERGENCY	10,320,476	63,841,440	74,161,916	0.133437	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,231,555	8,848,255	10,079,810	0.438922	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,994	8,651,421	8,656,415	0.508512	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	4,495,701	4,495,701			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	130,091,812	573,415,279	703,507,091			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	130,091,812	573,415,279	703,507,091			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY	0.000000		69.01
69.02	06902	CARDIOPULMONARY	0.000000		69.02
69.03	06903	SLEEP LAB	0.000000		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	IMED	0.000000		90.01
90.02	09002	ONCOLOGY	0.000000		90.02
90.03	09003	OUTPATIENT CENTER	0.000000		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000		90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	697,728	0	697,728	9,955	70.09	30.00
31.00	INTENSIVE CARE UNIT	321,272		321,272	3,105	103.47	31.00
40.00	SUBPROVIDER - IPF	240,775	0	240,775	923	260.86	40.00
41.00	SUBPROVIDER - IRF	127,190	0	127,190	987	128.87	41.00
43.00	NURSERY	83,403		83,403	1,662	50.18	43.00
44.00	SKILLED NURSING FACILITY	151,816		151,816	3,847	39.46	44.00
200.00	Total (lines 30 through 199)	1,622,184		1,622,184	20,479		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,663	186,650	30.00
31.00	INTENSIVE CARE UNIT	1,601	165,655	31.00
40.00	SUBPROVIDER - IPF	138	35,999	40.00
41.00	SUBPROVIDER - IRF	585	75,389	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,221	127,101	44.00
200.00	Total (lines 30 through 199)	8,208	590,794	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	912,804	86,422,916	0.010562	4,984,952	52,651	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	157,860	2,609,143	0.060503	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,283	5,872,879	0.000900	335,020	302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,068	109,498,391	0.002868	6,291,423	18,044	54.00
56.00	05600	RADIOISOTOPE	21,759	15,043,157	0.001446	153,733	222	56.00
60.00	06000	LABORATORY	169,766	78,004,560	0.002176	4,846,872	10,547	60.00
65.00	06500	RESPIRATORY THERAPY	60,256	8,488,726	0.007098	886,452	6,292	65.00
66.00	06600	PHYSICAL THERAPY	137,717	15,596,619	0.008830	1,454,952	12,847	66.00
69.00	06900	ELECTROCARDIOLOGY	290,812	48,474,481	0.005999	6,464,504	38,781	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	34,724	1,580,774	0.021966	0	0	69.02
69.03	06903	SLEEP LAB	40,594	2,211,029	0.018360	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,119	12,499,226	0.000570	1,281,422	730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,838	23,221,312	0.000381	4,234,579	1,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,188	126,412,450	0.000919	9,267,440	8,517	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	42,174	1,165,084	0.036198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	95,211	1,039,221	0.091618	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	121,716	4,163,278	0.029236	42,112	1,231	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	269,504	31,652,135	0.008515	136,084	1,159	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	116,997	6,516,128	0.017955	2,292	41	90.04
90.05	09005	DIABETES MGMT CLINIC	11,826	182,957	0.064638	0	0	90.05
91.00	09100	EMERGENCY	253,460	74,161,916	0.003418	5,284,311	18,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	250,076	10,079,810	0.024810	457,461	11,350	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,438,752	664,896,192		46,123,609	182,389	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,955	0.00	2,663	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,105	0.00	1,601	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	923	0.00	138	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	987	0.00	585	41.00
43.00	04300	NURSERY		0	1,662	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,847	0.00	3,221	44.00
200.00		Total (lines 30 through 199)		0	20,479		8,208	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	86,422,916	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,609,143	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,872,879	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	109,498,391	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	15,043,157	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	78,004,560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,488,726	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,596,619	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,474,481	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,580,774	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	2,211,029	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,499,226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,221,312	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,412,450	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,165,084	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,039,221	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,163,278	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	31,652,135	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	6,516,128	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	182,957	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	74,161,916	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,079,810	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	664,896,192		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,984,952	0	19,946,224	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	335,020	0	1,368,034	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,291,423	0	25,712,800	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	153,733	0	6,128,462	0	56.00
60.00	06000	LABORATORY	0.000000	4,846,872	0	10,906,127	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	886,452	0	1,190,838	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,454,952	0	181,008	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,464,504	0	13,729,988	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	839,913	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	712,348	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,281,422	0	2,470,293	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,234,579	0	5,984,670	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,267,440	0	44,470,667	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	42,112	0	1,229,552	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	136,084	0	14,407,369	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	2,292	0	303,912	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	5,284,311	0	14,168,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	457,461	0	1,799,734	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		46,123,609	0	165,550,010	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.235125	19,946,224	0	0	4,689,856	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	1,368,034	0	0	410,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	25,712,800	0	0	1,993,899	54.00
56.00	05600	RADIOISOTOPE	0.079908	6,128,462	0	0	489,713	56.00
60.00	06000	LABORATORY	0.152162	10,906,127	0	135	1,659,498	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	1,190,838	0	0	448,597	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	181,008	0	0	55,327	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	13,729,988	0	0	1,821,365	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	839,913	0	0	162,391	69.02
69.03	06903	SLEEP LAB	0.216099	712,348	0	0	153,938	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	2,470,293	0	0	436,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	5,984,670	0	0	1,568,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	44,470,667	0	65,302	9,404,657	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.260902	1,229,552	0	0	320,793	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	14,407,369	0	0	2,691,297	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	303,912	0	0	98,901	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.133437	14,168,071	0	83	1,890,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	1,799,734	0	0	789,943	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.508512		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		165,550,010	0	65,520	29,086,281	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		165,550,010	0	65,520	29,086,281	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	21		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,810		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	11		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	13,842		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	13,842		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	912,804	86,422,916	0.010562	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	157,860	2,609,143	0.060503	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,283	5,872,879	0.000900	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,068	109,498,391	0.002868	20,159	58	54.00
56.00	05600	RADIOISOTOPE	21,759	15,043,157	0.001446	0	0	56.00
60.00	06000	LABORATORY	169,766	78,004,560	0.002176	90,055	196	60.00
65.00	06500	RESPIRATORY THERAPY	60,256	8,488,726	0.007098	1,922	14	65.00
66.00	06600	PHYSICAL THERAPY	137,717	15,596,619	0.008830	6,266	55	66.00
69.00	06900	ELECTROCARDIOLOGY	290,812	48,474,481	0.005999	7,095	43	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	34,724	1,580,774	0.021966	0	0	69.02
69.03	06903	SLEEP LAB	40,594	2,211,029	0.018360	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,119	12,499,226	0.000570	12	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,838	23,221,312	0.000381	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,188	126,412,450	0.000919	34,307	32	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	42,174	1,165,084	0.036198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	95,211	1,039,221	0.091618	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	121,716	4,163,278	0.029236	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	269,504	31,652,135	0.008515	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	116,997	6,516,128	0.017955	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	11,826	182,957	0.064638	0	0	90.05
91.00	09100	EMERGENCY	253,460	74,161,916	0.003418	128,094	438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,079,810	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,188,676	664,896,192		287,910	836	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	86,422,916	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,609,143	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,872,879	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	109,498,391	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	15,043,157	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	78,004,560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,488,726	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,596,619	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,474,481	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,580,774	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	2,211,029	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,499,226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,221,312	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,412,450	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,165,084	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,039,221	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,163,278	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	31,652,135	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	6,516,128	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	182,957	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	74,161,916	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,079,810	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	664,896,192		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	20,159	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	90,055	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,922	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,266	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,095	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	34,307	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	128,094	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		287,910	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	912,804	86,422,916	0.010562	5,509	58	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	157,860	2,609,143	0.060503	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,283	5,872,879	0.000900	818	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,068	109,498,391	0.002868	46,652	134	54.00
56.00	05600	RADIOISOTOPE	21,759	15,043,157	0.001446	0	0	56.00
60.00	06000	LABORATORY	169,766	78,004,560	0.002176	70,299	153	60.00
65.00	06500	RESPIRATORY THERAPY	60,256	8,488,726	0.007098	2,730	19	65.00
66.00	06600	PHYSICAL THERAPY	137,717	15,596,619	0.008830	891,812	7,875	66.00
69.00	06900	ELECTROCARDIOLOGY	290,812	48,474,481	0.005999	10,540	63	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	34,724	1,580,774	0.021966	0	0	69.02
69.03	06903	SLEEP LAB	40,594	2,211,029	0.018360	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,119	12,499,226	0.000570	426	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,838	23,221,312	0.000381	349	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,188	126,412,450	0.000919	184,719	170	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	42,174	1,165,084	0.036198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	95,211	1,039,221	0.091618	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	121,716	4,163,278	0.029236	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	269,504	31,652,135	0.008515	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	116,997	6,516,128	0.017955	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	11,826	182,957	0.064638	0	0	90.05
91.00	09100	EMERGENCY	253,460	74,161,916	0.003418	1,518	5	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,079,810	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,188,676	664,896,192		1,215,372	8,478	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	86,422,916	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,609,143	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,872,879	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	109,498,391	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	15,043,157	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	78,004,560	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,488,726	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,596,619	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,474,481	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,580,774	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	2,211,029	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,499,226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,221,312	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,412,450	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,165,084	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,039,221	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,163,278	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	31,652,135	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	6,516,128	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	182,957	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	74,161,916	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,079,810	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	664,896,192		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,509	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	818	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	46,652	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	70,299	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,730	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	891,812	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,540	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	426	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	349	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	184,719	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	1,518	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,215,372	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.235125	0	584,596	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	0	36,022	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	0	1,132,919	0	0	54.00
56.00	05600	RADIOISOTOPE	0.079908	0	95,356	0	0	56.00
60.00	06000	LABORATORY	0.152162	0	888,991	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	0	47,696	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	0	61,050	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	0	252,239	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	6,432	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	16,715	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	0	94,838	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	0	29,098	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	0	1,359,605	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.260902	0	125,662	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	0	231,703	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	78,930	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	1,588	0	0	90.05
91.00	09100	EMERGENCY	0.133437	0	1,624,752	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	68,953	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.508512	0	378,759			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	7,115,904	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	7,115,904	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	137,453	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	10,821	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,852	0		54.00
56.00	05600	RADIOISOTOPE	7,620	0		56.00
60.00	06000	LABORATORY	135,271	0		60.00
65.00	06500	RESPIRATORY THERAPY	17,967	0		65.00
66.00	06600	PHYSICAL THERAPY	18,661	0		66.00
69.00	06900	ELECTROCARDIOLOGY	33,461	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	1,244	0		69.02
69.03	06903	SLEEP LAB	3,612	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,753	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,625	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,529	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	32,785	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	43,282	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	25,686	0		90.04
90.05	09005	DIABETES MGMT CLINIC	1,061	0		90.05
91.00	09100	EMERGENCY	216,802	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,265	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	192,603			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	1,308,353	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,308,353	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,955	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,955	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)	6,387	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,663	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,344,024	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,344,024	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,344,024	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)	1,239.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,302,067	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)	3,302,067	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,578,353	3,105	1,796.57	1,601	2,876,309	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)	8,385,545	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)	14,563,921	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)	352,305	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	182,389	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	534,694	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,029,227	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)	3,568	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,239.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,424,249	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	697,728	12,344,024	0.056524	4,424,249	250,076	90.00
91.00	Nursing Program cost	0	12,344,024	0.000000	4,424,249	0	91.00
92.00	Allied health cost	0	12,344,024	0.000000	4,424,249	0	92.00
93.00	All other Medical Education	0	12,344,024	0.000000	4,424,249	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	923	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)	923	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	138	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,699,995	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,699,995	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)	2,699,995	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,925.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	403,683	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)	403,683	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	43,195	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)	446,878	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)	35,999	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	836	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	36,835	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	410,043	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	240,775	2,699,995	0.089176	0	0	90.00
91.00	Nursing Program cost	0	2,699,995	0.000000	0	0	91.00
92.00	Allied health cost	0	2,699,995	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,699,995	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	987	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)	987	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	585	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,332,842	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,332,842	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,332,842	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)	1,350.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	789,984	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)	789,984	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	330,309	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,120,293	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	75,389	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,478	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	83,867	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,036,426	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	127,190	1,332,842	0.095428	0	0	90.00
91.00	Nursing Program cost	0	1,332,842	0.000000	0	0	91.00
92.00	Allied health cost	0	1,332,842	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,332,842	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,847	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,847	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)	3,847	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,221	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,931,792	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,931,792	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)	2,931,792	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1

Component CCN: 15-5305 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,931,792	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	762.10	71.00
72.00	Program routine service cost (line 9 x line 71)	2,454,724	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,454,724	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,454,724	83.00
84.00	Program inpatient ancillary services (see instructions)	1,014,611	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,469,335	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 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)	9,955	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,955	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)	6,387	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	104	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)	1,662	15.00
16.00	Nursery days (title V or XIX only)	85	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,344,024	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,344,024	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,344,024	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)	1,239.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	128,958	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)	128,958	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 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)	1,332,855	1,662	801.96	85	68,167	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,578,353	3,105	1,796.57	29	52,101	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)	165,375	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)	414,601	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)	3,568	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,239.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,424,249	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	697,728	12,344,024	0.056524	4,424,249	250,076	90.00
91.00	Nursing Program cost	0	12,344,024	0.000000	4,424,249	0	91.00
92.00	Allied health cost	0	12,344,024	0.000000	4,424,249	0	92.00
93.00	All other Medical Education	0	12,344,024	0.000000	4,424,249	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	923	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)	923	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	375	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)	1,662	15.00
16.00	Nursery days (title V or XIX only)	85	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,699,995	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,699,995	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)	2,699,995	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,925.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,096,965	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)	1,096,965	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,096,965	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description					1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	240,775	2,699,995	0.089176	0	0	90.00
91.00	Nursing Program cost	0	2,699,995	0.000000	0	0	91.00
92.00	Allied health cost	0	2,699,995	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,699,995	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,347,550		30.00
31.00	03100	INTENSIVE CARE UNIT		3,706,530		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		326		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	4,984,952	1,172,087	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	335,020	100,637	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	6,291,423	487,868	54.00
56.00	05600	RADIOISOTOPE	0.079908	153,733	12,284	56.00
60.00	06000	LABORATORY	0.152162	4,846,872	737,510	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	886,452	333,933	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	1,454,952	444,725	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	6,464,504	857,555	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	1,281,422	226,364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	4,234,579	1,109,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	9,267,440	1,959,878	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260902	42,112	10,987	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	136,084	25,420	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	2,292	746	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	90.05
91.00	09100	EMERGENCY	0.133437	5,284,311	705,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	457,461	200,790	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,123,609	8,385,545	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)		46,123,609		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		244,485		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	20,159	1,563	54.00
56.00	05600	RADIOISOTOPE	0.079908	0	0	56.00
60.00	06000	LABORATORY	0.152162	90,055	13,703	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	1,922	724	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	6,266	1,915	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	7,095	941	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	12	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	34,307	7,255	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260902	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	90.05
91.00	09100	EMERGENCY	0.133437	128,094	17,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		287,910	43,195	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)		287,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		862,875		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	5,509	1,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	818	246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	46,652	3,618	54.00
56.00	05600	RADIOISOTOPE	0.079908	0	0	56.00
60.00	06000	LABORATORY	0.152162	70,299	10,697	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	2,730	1,028	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	891,812	272,594	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	10,540	1,398	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	426	75	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	349	91	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	184,719	39,064	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260902	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	90.05
91.00	09100	EMERGENCY	0.133437	1,518	203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,215,372	330,309	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,215,372		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	115,443	8,952	54.00
56.00	05600	RADIOISOTOPE	0.079908	0	0	56.00
60.00	06000	LABORATORY	0.152162	583,536	88,792	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	52,627	19,825	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	2,092,534	639,610	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	18,226	2,418	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	12,961	2,290	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	1,194,570	252,628	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.260902	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	252	47	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	90.05
91.00	09100	EMERGENCY	0.133437	370	49	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,070,519	1,014,611	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,070,519		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 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		320,745		30.00
31.00	03100	INTENSIVE CARE UNIT		73,364		31.00
40.00	04000	SUBPROVIDER - IPF		63,740		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		119,060		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	7,959	1,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	18,773	5,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	108,181	8,389	54.00
56.00	05600	RADIOISOTOPE	0.079908	7,290	583	56.00
60.00	06000	LABORATORY	0.152162	181,659	27,642	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	47,712	17,973	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	12,829	3,921	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	140,036	18,577	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	10,322	1,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	6,470	1,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	266,736	56,409	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.731891	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.106207	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.260902	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	408	273	90.05
91.00	09100	EMERGENCY	0.133437	154,230	20,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		962,605	165,375	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)		962,605		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/25/2024 11:51 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		64,937		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.235125	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930409	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.300392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077545	0	0	54.00
56.00	05600	RADIOISOTOPE	0.079908	0	0	56.00
60.00	06000	LABORATORY	0.152162	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.376707	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.305663	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.132656	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.193343	0	0	69.02
69.03	06903	SLEEP LAB	0.216099	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176651	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.262042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211480	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.731891	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.106207	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.260902	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.186800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.325426	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.668381	0	0	90.05
91.00	09100	EMERGENCY	0.133437	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.438922	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,986,846	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,892,251	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	6,688	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	4,256,542	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	86.17	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	14.47	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	14.47	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.167924	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.167148	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.167148	21.00
22.00	IME payment adjustment (see instructions)	1,210,382	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	371,209	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	1,210,382	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	371,209	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.53	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.09	31.00
32.00	Sum of lines 30 and 31	20.62	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.63	33.00
34.00	Disproportionate share adjustment (see instructions)	230,046	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000101243	0.000107121	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	728,141	736,393	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	183,532	550,781	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	734,313		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,060,526		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	16,431,735	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,194,882	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	343,885	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	15,837	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	17,986,339	59.00
60.00	Primary payer payments	4,130	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,982,209	61.00
62.00	Deductibles billed to program beneficiaries	1,933,116	62.00
63.00	Coinsurance billed to program beneficiaries	1,200	63.00
64.00	Allowable bad debts (see instructions)	67,263	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	43,721	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,091,614	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-1,989	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	329,437	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		40,888	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,378,174	71.00
71.01	Sequestration adjustment (see instructions)		327,563	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		15,200,079	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		850,532	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		309,041	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		6,688	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		164	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet DSH | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	1.53	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	19.09	0.00			19.09	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	20.62	0.00			19.09	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	86.17	0.00			86.17	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	6.63	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	218	0			218	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	167	0			167	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	5	0			5	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	1,700	0			1,700	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	167	0			167	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,257	0			2,257	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	11,154	0			11,154	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	672	0			672	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	11,826	0			11,826	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	19.09	0.00			19.09	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet DSH | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6.23		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		6.23		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		6.23		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet DSH Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		Revised Percentage
		6.00
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.16
30.00	Line 28 or 29 as applicable	5.16
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,842	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,086,281	2.00
3.00	OPPS or REH payments	29,623,782	3.00
4.00	Outlier payment (see instructions)	7,636	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	13,842	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	65,520	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)	65,520	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)	65,520	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	51,678	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)	13,842	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)	29,631,418	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,215,789	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)	24,429,471	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	496,383	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	24,925,854	30.00
31.00	Primary payer payments	6,198	31.00
32.00	Subtotal (line 30 minus line 31)	24,919,656	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)	83,942	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	54,562	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	24,974,218	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-141	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)	24,974,359	40.00
40.01	Sequestration adjustment (see instructions)	499,487	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	24,430,039	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)	44,833	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)	7,636	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,135,479		24,430,039	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	02/15/2023	64,600		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)		64,600		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)		15,200,079		24,430,039	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		850,532		44,833	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		16,050,611		24,474,872	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		105,276		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)		105,276		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		4,954		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		110,230		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,100,990		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)		1,100,990		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		5,770		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,106,760		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,657,454		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)		1,657,454		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,657,454		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part II Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	152,178	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.27	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.27	8.00
9.00	Average Daily Census (see instructions)	2.528767	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.053635	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	8,162	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	160,340	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	160,340	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	160,340	18.00
19.00	Deductibles	50,408	19.00
20.00	Subtotal (line 18 minus line 19)	109,932	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	109,932	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,920	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	2,548	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	112,480	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	112,480	31.00
31.01	Sequestration adjustment (see instructions)	2,250	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	105,276	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	4,954	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.053635	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.053634	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part III Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,083,460	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	26,870	3.00
4.00	Outlier Payments	22,173	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	2.704110	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,132,503	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,132,503	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,132,503	19.00
20.00	Deductibles	3,156	20.00
21.00	Subtotal (line 19 minus line 20)	1,129,347	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,129,347	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,129,347	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,129,347	32.00
32.01	Sequestration adjustment (see instructions)	22,587	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	1,100,990	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	5,770	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	22,173	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,823,081	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,823,081	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	131,801	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,691,280	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,691,280	15.00
15.01	Sequestration adjustment (see instructions)	33,826	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	1,657,454	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2024 11:51 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	414,601		1.00
2.00	Medical and other services		1,308,353	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	414,601	1,308,353	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)	414,601	1,308,353	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	962,605	7,115,904	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)	962,605	7,115,904	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)	962,605	7,115,904	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	548,004	5,807,551	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)	414,601	1,308,353	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)	414,601	1,308,353	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)	414,601	1,308,353	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)	414,601	1,308,353	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-414,601	-1,308,353	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,096,965		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)	1,096,965	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)	1,096,965	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,096,965	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	1,096,965	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Skilled Nursing Facility	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-4 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	14.24	0.50		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	14.24	0.50		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	14.24	0.50		17.00
18.00	Per resident amount	105,000.00	105,000.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	1,495,200	52,500	1,547,700	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,547,700	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-4 | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	4,987	810	811		26.00
27.00	Total Inpatient Days (see instructions)	12,074	12,074	12,074		27.00
28.00	Ratio of inpatient days to total inpatient days	0.413036	0.067086	0.067169		28.00
29.00	Program direct GME amount	639,256	103,829	103,957	847,042	29.00
29.01	Percent reduction for MA DGME		3.26	3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		3,385	3,389	6,774	30.00
31.00	Net Program direct GME amount				840,268	31.00

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	20,408,897	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	4,130	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	20,404,767	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	29,459,582	42.00
43.00	Primary payer payments (see instructions)	6,198	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	29,453,384	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	49,858,151	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.409256	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.590744	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	840,268	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	343,885	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	496,383	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E-5 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	6,688	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	164	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 1/25/2024 11:51 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	32,056,290	0	0	0	1.00
2.00	Temporary investments	72,868,952	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,368,679	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	8,390,588	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)	137,684,509	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,208,673	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	124,027,093	0	0	0	15.00
16.00	Accumulated depreciation	-89,067,496	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	166,968,190	0	0	0	19.00
20.00	Accumulated depreciation	-107,056,796	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	106,079,664	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	69,294,839	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	11,855,190	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	81,150,029	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	324,914,202	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,720,342	0	0	0	37.00
38.00	Salaries, wages, and fees payable	25,680,522	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,917,375	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	846,523				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,269,376	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	36,434,138	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	62,791,776	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	62,791,776	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	99,225,914	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	225,688,288				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)	225,688,288	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	324,914,202	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 1/25/2024 11:51 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		223,113,355		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		94,115,410				2.00
3.00	Total (sum of line 1 and line 2)		317,228,765		0		3.00
4.00	IDENTIFIED ON TRIAL BALANCE	1,044,027		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)		1,044,027		0		10.00
11.00	Subtotal (line 3 plus line 10)		318,272,792		0		11.00
12.00	FREESTANDING RHC DEPARTMENTS	266,844		0		0	12.00
13.00	HOME OFFICE DEPARTMENTS	92,317,660		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)		92,584,504		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		225,688,288		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	IDENTIFIED ON TRIAL BALANCE		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	FREESTANDING RHC DEPARTMENTS		0		12.00
13.00	HOME OFFICE DEPARTMENTS		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: 15-0115 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/25/2024 11:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,242,735		25,242,735	1.00
2.00	SUBPROVIDER - IPF	1,780,691		1,780,691	2.00
3.00	SUBPROVIDER - IRF	1,541,391		1,541,391	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,520,004		1,520,004	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)	30,084,821		30,084,821	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,809,898		9,809,898	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)	9,809,898		9,809,898	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,894,719		39,894,719	17.00
18.00	Ancillary services	99,572,007	548,470,501	648,042,508	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,165,084	1,165,084	20.00
20.01	RURAL HEALTH CLINIC II	0	1,039,221	1,039,221	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,709,671	4,709,671	22.00
23.00	AMBULANCE SERVICES	4,994	8,651,421	8,656,415	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIANS	0	112,317,791	112,317,791	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	139,471,720	676,353,689	815,825,409	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		184,802,337		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)		184,802,337		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 1/25/2024 11:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	815,825,409	1.00
2.00	Less contractual allowances and discounts on patients' accounts	556,736,561	2.00
3.00	Net patient revenues (line 1 minus line 2)	259,088,848	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	184,802,337	4.00
5.00	Net income from service to patients (line 3 minus line 4)	74,286,511	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	8,000,766	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	634,251	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	473,546	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	MISCELLANEOUS	10,720,336	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	19,828,899	25.00
26.00	Total (line 5 plus line 25)	94,115,410	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)	94,115,410	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H | Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	2,250,604	0	195,940	11,169	49,760	2,507,473	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	50,540	50,540	12.00
13.00	Drugs	0	0	0	0	25,291	25,291	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,250,604	0	195,940	11,169	125,591	2,583,304	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-2,017,030	490,443	0	490,443			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	964,104	964,104	0	964,104			6.00
7.00	Physical Therapy	555,692	555,692	0	555,692			7.00
8.00	Occupational Therapy	343,703	343,703	0	343,703			8.00
9.00	Speech Pathology	20,454	20,454	0	20,454			9.00
10.00	Medical Social Services	9,828	9,828	0	9,828			10.00
11.00	Home Health Aide	123,249	123,249	0	123,249			11.00
12.00	Supplies (see instructions)	0	50,540	-50,540	0			12.00
13.00	Drugs	0	25,291	-25,291	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	2,583,304	-75,831	2,507,473			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0115 HHA CCN: 15-7222

Period: From 07/01/2022 To 06/30/2023

Worksheet H-1 Part I Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	490,443	0	0	0	0	490,443	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	964,104	0	0	0	0	964,104	6.00
7.00	Physical Therapy	555,692	0	0	0	0	555,692	7.00
8.00	Occupational Therapy	343,703	0	0	0	0	343,703	8.00
9.00	Speech Pathology	20,454	0	0	0	0	20,454	9.00
10.00	Medical Social Services	9,828	0	0	0	0	9,828	10.00
11.00	Home Health Aide	123,249	0	0	0	0	123,249	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,507,473	0	0	0	0	2,507,473	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	490,443			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	234,423	1,198,527		6.00
7.00	Physical Therapy	135,117	690,809		7.00
8.00	Occupational Therapy	83,572	427,275		8.00
9.00	Speech Pathology	4,973	25,427		9.00
10.00	Medical Social Services	2,390	12,218		10.00
11.00	Home Health Aide	29,968	153,217		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		2,507,473		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-1 Part II | Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-490,443	2,017,030	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	964,104	6.00
7.00	Physical Therapy	0	0	0	0	0	555,692	7.00
8.00	Occupational Therapy	0	0	0	0	0	343,703	8.00
9.00	Speech Pathology	0	0	0	0	0	20,454	9.00
10.00	Medical Social Services	0	0	0	0	0	9,828	10.00
11.00	Home Health Aide	0	0	0	0	0	123,249	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-490,443	2,017,030	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		490,443	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.243151	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 HHA CCN: 15-7222

Period: From 07/01/2022 To 06/30/2023

Worksheet H-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	29,775	22,717	131,869	184,361	26,139	1.00
2.00	Skilled Nursing Care	1,198,527	0	0	273,105	1,471,632	208,649	2.00
3.00	Physical Therapy	690,809	0	0	154,953	845,762	119,913	3.00
4.00	Occupational Therapy	427,275	0	0	97,092	524,367	74,345	4.00
5.00	Speech Pathology	25,427	0	0	5,901	31,328	4,442	5.00
6.00	Medical Social Services	12,218	0	0	2,924	15,142	2,147	6.00
7.00	Home Health Aide	153,217	0	0	29,332	182,549	25,882	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,507,473	29,775	22,717	695,176	3,255,141	461,517	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	25,566	0	8,059	0	9,566	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	20,782	0	2.00
3.00	Physical Therapy	0	0	0	0	10,395	0	3.00
4.00	Occupational Therapy	0	0	0	0	6,034	0	4.00
5.00	Speech Pathology	0	0	0	0	354	0	5.00
6.00	Medical Social Services	0	0	0	0	274	0	6.00
7.00	Home Health Aide	0	0	0	0	3,828	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	25,566	0	8,059	0	51,233	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 HHA CCN: 15-7222

Period: From 07/01/2022 To 06/30/2023

Worksheet H-2 Part I Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I

PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
		14.00	15.00	16.00	21.00	22.00	24.00	
1.00	Administrative and General	1,589	0	0	0	0	255,280	1.00
2.00	Skilled Nursing Care	0	0	4,053	0	0	1,705,116	2.00
3.00	Physical Therapy	0	0	2,734	0	0	978,804	3.00
4.00	Occupational Therapy	0	0	1,489	0	0	606,235	4.00
5.00	Speech Pathology	0	0	69	0	0	36,193	5.00
6.00	Medical Social Services	0	0	19	0	0	17,582	6.00
7.00	Home Health Aide	0	0	1,419	0	0	213,678	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,589	0	9,783	0	0	3,812,888	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	255,280					1.00
2.00	Skilled Nursing Care	0	1,705,116	122,352	1,827,468			2.00
3.00	Physical Therapy	0	978,804	70,235	1,049,039			3.00
4.00	Occupational Therapy	0	606,235	43,501	649,736			4.00
5.00	Speech Pathology	0	36,193	2,597	38,790			5.00
6.00	Medical Social Services	0	17,582	1,262	18,844			6.00
7.00	Home Health Aide	0	213,678	15,333	229,011			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	3,812,888	255,280	3,812,888			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.071756				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 HHA CCN: 15-7222

Period: From 07/01/2022 To 06/30/2023

Worksheet H-2 Part II Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,758	3,758	426,314	0	184,361	3,758	1.00
2.00	Skilled Nursing Care	0	0	882,910	0	1,471,632	0	2.00
3.00	Physical Therapy	0	0	500,941	0	845,762	0	3.00
4.00	Occupational Therapy	0	0	313,883	0	524,367	0	4.00
5.00	Speech Pathology	0	0	19,078	0	31,328	0	5.00
6.00	Medical Social Services	0	0	9,453	0	15,142	0	6.00
7.00	Home Health Aide	0	0	94,826	0	182,549	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,758	3,758	2,247,405		3,255,141	3,758	20.00
21.00	Total cost to be allocated	29,775	22,717	695,176		461,517	25,566	21.00
22.00	Unit cost multiplier	7.923097	6.044971	0.309324		0.141781	6.803087	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	3,758	0	12,230	0	25,437	1.00
2.00	Skilled Nursing Care	0	0	0	26,572	0	0	2.00
3.00	Physical Therapy	0	0	0	13,291	0	0	3.00
4.00	Occupational Therapy	0	0	0	7,715	0	0	4.00
5.00	Speech Pathology	0	0	0	452	0	0	5.00
6.00	Medical Social Services	0	0	0	350	0	0	6.00
7.00	Home Health Aide	0	0	0	4,894	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	3,758	0	65,504	0	25,437	20.00
21.00	Total cost to be allocated	0	8,059	0	51,233	0	1,589	21.00
22.00	Unit cost multiplier	0.000000	2.144492	0.000000	0.782135	0.000000	0.062468	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-2 Part II | Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I | PPS

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		15.00	16.00	21.00	22.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	1,862,946	0	0			2.00
3.00	Physical Therapy	0	1,256,233	0	0			3.00
4.00	Occupational Therapy	0	684,196	0	0			4.00
5.00	Speech Pathology	0	31,567	0	0			5.00
6.00	Medical Social Services	0	8,609	0	0			6.00
7.00	Home Health Aide	0	652,150	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	4,495,701	0	0			20.00
21.00	Total cost to be allocated	0	9,783	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.002176	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,827,468		1,827,468	7,790	234.59	1.00
2.00	Physical Therapy	3.00	1,049,039	0	1,049,039	5,253	199.70	2.00
3.00	Occupational Therapy	4.00	649,736	0	649,736	2,861	227.10	3.00
4.00	Speech Pathology	5.00	38,790	0	38,790	132	293.86	4.00
5.00	Medical Social Services	6.00	18,844		18,844	36	523.44	5.00
6.00	Home Health Aide	7.00	229,011		229,011	2,727	83.98	6.00
7.00	Total (sum of lines 1-6)		3,812,888	0	3,812,888	18,799		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	4,201			8.00
9.00	Physical Therapy		99915	0	3,251			9.00
10.00	Occupational Therapy		99915	0	1,797			10.00
11.00	Speech Pathology		99915	0	74			11.00
12.00	Medical Social Services		99915	0	21			12.00
13.00	Home Health Aide		99915	0	1,489			13.00
14.00	Total (sum of lines 8-13)			0	10,833			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	39,108	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,201		0	985,513		1.00
2.00	Physical Therapy	0	3,251		0	649,225		2.00
3.00	Occupational Therapy	0	1,797		0	408,099		3.00
4.00	Speech Pathology	0	74		0	21,746		4.00
5.00	Medical Social Services	0	21		0	10,992		5.00
6.00	Home Health Aide	0	1,489		0	125,046		6.00
7.00	Total (sum of lines 1-6)	0	10,833		0	2,200,621		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	985,513	1.00
2.00	Physical Therapy	649,225	2.00
3.00	Occupational Therapy	408,099	3.00
4.00	Speech Pathology	21,746	4.00
5.00	Medical Social Services	10,992	5.00
6.00	Home Health Aide	125,046	6.00
7.00	Total (sum of lines 1-6)	2,200,621	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115
HHA CCN: 15-7222

Period:
From 07/01/2022
To 06/30/2023

Worksheet H-3
Part II
Date/Time Prepared:
1/25/2024 11:51 am

Home Health Agency I

PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.305663	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.176651	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.211480	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/25/2024 11:51 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,087,396	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	463,674	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	23,695	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,960	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	154,132	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	6,428	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		2,822	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,737,463	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,737,463	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,737,463	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	1,737,463	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,737,463	31.00
31.01	Sequestration adjustment (see instructions)	0	34,749	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	1,702,713	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-5 | Date/Time Prepared: 1/25/2024 11:51 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,702,713	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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,702,713	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,702,714	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,031,797	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	164	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	27.85	3.00
4.00	Number of interns & residents (see instructions)	14.47	4.00
5.00	Indirect medical education percentage (see instructions)	15.79	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	162,921	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,194,882	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 1/25/2024 11:51 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	418,977	0	418,977	-410,565	8,412	1.00
2.00	Physician Assistant	0	0	0	11,583	11,583	2.00
3.00	Nurse Practitioner	0	0	0	247,051	247,051	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	101,067	101,067	9.00
10.00	Subtotal (sum of lines 1 through 9)	418,977	0	418,977	-50,864	368,113	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	1,252	1,252	0	1,252	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	1,252	1,252	0	1,252	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	418,977	1,252	420,229	-50,864	369,365	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	12,304	12,304	0	12,304	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	12,304	12,304	0	12,304	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	66,842	66,842	0	66,842	29.00
30.00	Administrative Costs	0	45,205	45,205	50,864	96,069	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	112,047	112,047	50,864	162,911	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	418,977	125,603	544,580	0	544,580	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 1/25/2024 11:51 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	8,412		1.00
2.00	Physician Assistant	0	11,583		2.00
3.00	Nurse Practitioner	0	247,051		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	101,067		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	368,113		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	1,252		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	1,252		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	369,365		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	12,304		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	12,304		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	66,842		29.00
30.00	Administrative Costs	-640	95,429		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-640	162,271		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-640	543,940		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 1/25/2024 11:51 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	583,911	0	583,911	-334,401	249,510	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	119,664	119,664	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	134,827	134,827	9.00
10.00	Subtotal (sum of lines 1 through 9)	583,911	0	583,911	-79,910	504,001	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	1,302	1,302	0	1,302	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	1,302	1,302	0	1,302	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	583,911	1,302	585,213	-79,910	505,303	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	15,387	15,387	0	15,387	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	15,387	15,387	0	15,387	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,655	2,655	0	2,655	29.00
30.00	Administrative Costs	0	67,397	67,397	79,910	147,307	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	70,052	70,052	79,910	149,962	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	583,911	86,741	670,652	0	670,652	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 1/25/2024 11:51 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	249,510		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	119,664		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	134,827		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	504,001		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	1,302		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	1,302		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	505,303		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	15,387		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	15,387		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,655		29.00
30.00	Administrative Costs	-119	147,188		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-119	149,843		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-119	670,533		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 1/25/2024 11:51 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.10	0	2,100	210		2.00
3.00	Nurse Practitioner	1.62	4,522	2,100	3,402		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.72	4,522		3,612	4,522	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.72	4,522			4,522	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)					369,365	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					12,304	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					381,669	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.967763	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					162,271	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					308,774	15.00
16.00	Total overhead (sum of lines 14 and 15)					471,045	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					471,045	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					455,860	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					825,225	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 1/25/2024 11:51 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.07	3,237	4,200	4,494		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.92	734	2,100	1,932		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.99	3,971		6,426	6,426	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.99	3,971			6,426	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					505,303	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					15,387	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					520,690	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.970449	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					149,843	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					479,061	15.00
16.00	Total overhead (sum of lines 14 and 15)					628,904	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					628,904	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					610,319	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,115,622	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 1/25/2024 11:51 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)			825,225	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			8,244	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			816,981	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,522	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,522	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			180.67	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	671	653		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	75,823	82,278		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	158,101		16.00
16.01	Total program charges (see instructions)(from contractor's records)		295,605		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,366		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,870		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.)		94,114		16.04
16.05	Total program cost (see instructions)	0	96,984		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		37,588		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,530		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		96,984		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,211		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		102,195		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		102,195		26.00
26.01	Sequestration adjustment (see instructions)		2,044		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		92,473		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		7,678		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: 15-0115 Component CCN: 15-8508	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,115,622	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			11,764	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,103,858	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,426	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,426	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			171.78	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	794	886		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	89,722	111,636		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	201,358		16.00
16.01	Total program charges (see instructions)(from contractor's records)		318,462		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,873		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,462		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.)		119,498		16.04
16.05	Total program cost (see instructions)	0	133,960		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		37,524		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,613		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		133,960		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,198		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		141,158		22.00
23.00	Allowable bad debts (see instructions)		28		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		18		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		141,176		26.00
26.01	Sequestration adjustment (see instructions)		2,824		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		128,226		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,126		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: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 1/25/2024 11:51 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)	368,113	368,113	368,113	368,113	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000066	0.002174	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	24	800	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	547	2,319	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	571	3,119	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	369,365	369,365	369,365	369,365	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	455,860	455,860	455,860	455,860	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001546	0.008444	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	705	3,849	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,276	6,968	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	99	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	425.33	70.38	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	68	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)	425	4,786	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		8,244	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)		5,211	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 1/25/2024 11:51 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)	504,001	504,001	504,001	504,001	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000226	0.001952	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	114	984	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,005	2,225	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,119	3,209	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	505,303	505,303	505,303	505,303	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	610,319	610,319	610,319	610,319	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004194	0.006351	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,560	3,876	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,679	7,085	0	0	10.00
11.00	Total number of injections/infusions (from your records)	11	95	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	425.36	74.58	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	68	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,127	5,071	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)	11,764	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)	7,198	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 1/25/2024 11:51 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			92,473	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			92,473	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			7,678	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			100,151	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 1/25/2024 11:51 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		128,226	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		128,226	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		10,126	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		138,352	7.00

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