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: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 9:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 9:32 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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	Gregg Malott		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Gregg Malott			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	168,636	-481,897	0	8,899	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	81,172	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		70,398		0	10.00
10.01	RURAL HEALTH CLINIC II	0		25,159		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-4,863		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		3,696		0	10.03
200.00	TOTAL	0	249,808	-387,507	0	8,899	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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 9:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	PULASKI MEMORIAL RHC - KNOX MEDICAL	158554	99915		07/06/2020	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 9:32 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.	2	N		23.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 9:32 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.				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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 9:32 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)	N	63.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 9:32 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 9:32 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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	195,660	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	Y	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

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

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

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

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

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

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

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

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

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

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		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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 9:32 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	01/08/2024	Y	01/08/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.	MICHAEL		ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRINI@BLUEANDCO.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 9:32 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	19,848.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	19,848.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		25	9,125	19,848.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 9:32 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)	345	6	801			1.00
2.00	HMO and other (see instructions)	90	16				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	353	0	353			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	169			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	698	6	1,323			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	0			13.00
14.00	Total (see instructions)	698	6	1,323	0.00	185.39	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,663	6,624	24,983	0.00	46.63	26.00
26.01	RURAL HEALTH CLINIC II	1,297	622	4,352	0.00	2.45	26.01
26.02	RURAL HEALTH CLINIC III	363	225	1,482	0.00	2.10	26.02
26.03	RURAL HEALTH CLINIC IV	1,048	1,032	4,472	0.00	4.37	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	240.94	27.00
28.00	Observation Bed Days		48	624			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 9:32 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	100	2	230	1.00
2.00	HMO and other (see instructions)			17	6		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	100	2	230	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 9:32 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			540 HOSPITAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC		IN	46996-	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		PULASKI				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	17:30	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 2/27/2024 9:32 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	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 9:32 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			NORTH LANE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON		IN	46366-1226	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		PULASKI				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: 15-1305
Component CCN: 15-8527

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/27/2024 9:32 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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 9:32 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 E MONTGOMERY STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRANCESVILLE		IN	47946-8087	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	09:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			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		PULASKI				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	19:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8528

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/27/2024 9:32 am

RHC III

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 9:32 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2 S. PEARL STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNOX		IN	46534	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	19:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				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						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	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 2/27/2024 9:32 am
		RHC IV	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 9:32 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.456369	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	811,738	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	235,830	5.00
6.00	Medicaid charges	12,041,051	6.00
7.00	Medicaid cost (line 1 times line 6)	5,495,162	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	4,447,594	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,447,594	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	10,907	186,804	197,711	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,978	186,804	191,782	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	4,978	186,804	191,782	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	843,549	26.00
27.00	Medicare reimbursable bad debts (see instructions)	270,212	27.00
27.01	Medicare allowable bad debts (see instructions)	415,712	27.01
28.00	Non-Medicare bad debt amount (see instructions)	427,837	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	340,752	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	532,534	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,980,128	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 9:32 am

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,068,895	2,068,895	61,504	2,130,399	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,701,723	5,701,723	0	5,701,723	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,910,093	4,827,296	7,737,389	102,620	7,840,009	5.00
7.00	00700	OPERATION OF PLANT	384,638	632,547	1,017,185	795,770	1,812,955	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,949	69,536	78,485	0	78,485	8.00
9.00	00900	HOUSEKEEPING	225,382	145,801	371,183	0	371,183	9.00
10.00	01000	DIETARY	225,361	196,863	422,224	-365	421,859	10.00
13.00	01300	NURSING ADMINISTRATION	414,344	59,987	474,331	0	474,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,870	41,397	70,267	0	70,267	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,369	45,550	369,919	-31,090	338,829	16.00
17.00	01700	SOCIAL SERVICE	53,566	18	53,584	0	53,584	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,897,552	153,777	2,051,329	90,487	2,141,816	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	651,662	138,321	789,983	892,666	1,682,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	558,790	558,790	-1,608	557,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,783	610,534	1,627,317	-299,397	1,327,920	54.00
60.00	06000	LABORATORY	782,317	859,748	1,642,065	-42,963	1,599,102	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	51,349	51,349	0	51,349	63.00
65.00	06500	RESPIRATORY THERAPY	373,077	38,373	411,450	0	411,450	65.00
66.00	06600	PHYSICAL THERAPY	974,835	25,659	1,000,494	-282	1,000,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,476	1,633	187,109	0	187,109	67.00
68.00	06800	SPEECH PATHOLOGY	0	193	193	0	193	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,341	14,341	0	14,341	69.00
69.01	06901	CARDIAC REHABILITATION	72,864	3,816	76,680	-565	76,115	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749,715	749,715	-79,676	670,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,676	79,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,262	2,427,035	2,511,297	-6,141	2,505,156	73.00
76.00	03020	ONCOLOGY	148,223	48,399	196,622	-141	196,481	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,926,165	470,490	6,396,655	-1,551,061	4,845,594	88.00
88.01	08801	RURAL HEALTH CLINIC II	571,461	99,739	671,200	102,322	773,522	88.01
88.02	08802	RURAL HEALTH CLINIC III	134,932	32,052	166,984	68,365	235,349	88.02
88.03	08803	RURAL HEALTH CLINIC IV	531,156	96,176	627,332	48,689	676,021	88.03
90.00	09000	CLINIC	66,235	197,276	263,511	0	263,511	90.00
90.01	09001	WOUND CARE	129,683	233,033	362,716	11,354	374,070	90.01
91.00	09100	EMERGENCY	1,252,793	1,502,889	2,755,682	-1,758	2,753,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,375,048	22,102,951	41,477,999	238,406	41,716,405	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,079	209,062	427,141	0	427,141	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	21,369	21,369	0	21,369	192.02
192.03	19203	CULVER	151,193	117,581	268,774	0	268,774	192.03
194.00	07950	MARKETING	111,237	165,379	276,616	-238,406	38,210	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,855,557	22,616,342	42,471,899	0	42,471,899	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-13,241	2,117,158		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,701,723		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,740,239	6,099,770		5.00
7.00	00700	OPERATION OF PLANT	-278	1,812,677		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,485		8.00
9.00	00900	HOUSEKEEPING	0	371,183		9.00
10.00	01000	DIETARY	-58,559	363,300		10.00
13.00	01300	NURSING ADMINISTRATION	0	474,331		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-15,660	54,607		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,577	334,252		16.00
17.00	01700	SOCIAL SERVICE	0	53,584		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-481,899	1,659,917		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-933,477	749,172		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-550,000	7,182		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,327,920		54.00
60.00	06000	LABORATORY	0	1,599,102		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	51,349		63.00
65.00	06500	RESPIRATORY THERAPY	0	411,450		65.00
66.00	06600	PHYSICAL THERAPY	0	1,000,212		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,109		67.00
68.00	06800	SPEECH PATHOLOGY	0	193		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,434	8,907		69.00
69.01	06901	CARDIAC REHABILITATION	0	76,115		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	670,039		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,676		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,505,156		73.00
76.00	03020	ONCOLOGY	-42,877	153,604		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,845,594		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	773,522		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	235,349		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-13,092	662,929		88.03
90.00	09000	CLINIC	0	263,511		90.00
90.01	09001	WOUND CARE	-96,933	277,137		90.01
91.00	09100	EMERGENCY	0	2,753,924		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,956,266	37,760,139		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-13,092	414,049		192.00
192.01	19201	KNOX RHC	0	0		192.01
192.02	19202	RETAIL PHARMACY	0	21,369		192.02
192.03	19203	CULVER	0	268,774		192.03
194.00	07950	MARKETING	0	38,210		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,969,358	38,502,541		200.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 9:32 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	61,504		1.00
	0		0	61,504		
	B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	95,871	142,535		1.00
	0		95,871	142,535		
	C - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	79,676		1.00
	0		0	79,676		
	D - PHYSICIAN SALARIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	95,028	0		1.00
2.00	OPERATING ROOM	50.00	927,909	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	114,639	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	60,732	0		4.00
5.00	RURAL HEALTH CLINIC IV	88.03	27,648	0		5.00
6.00	WOUND CARE	90.01	11,354	0		6.00
	0		1,237,310	0		
	E - PATIENT ACCOUNTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	167,782	0		1.00
	0		167,782	0		
	F - RHC DEPT 175 RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	0	22,413		1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	7,633		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	23,032		3.00
	0		0	53,078		
	H - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	795,770		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
	TOTALS		0	795,770		
500.00	Grand Total: Increases		1,500,963	1,132,563		500.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 9:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,504	12		1.00
	0		0	61,504			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	95,871	142,535	0		1.00
	0		95,871	142,535			
	C - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	79,676	0		1.00
	0		0	79,676			
	D - PHYSICIAN SALARIES RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	1,202,580	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	34,730	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		1,237,310	0			
	E - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	167,782	0	0		1.00
	0		167,782	0			
	F - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	53,078	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	53,078			
	H - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	242,064	0		1.00
2.00	DIETARY	10.00	0	365	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	31,090	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4,541	0		4.00
5.00	OPERATING ROOM	50.00	0	35,243	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	1,608	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299,397	0		7.00
8.00	LABORATORY	60.00	0	42,963	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	282	0		9.00
10.00	CARDIAC REHABILITATION	69.01	0	565	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,141	0		11.00
12.00	ONCOLOGY	76.00	0	141	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	127,621	0		13.00
14.00	RURAL HEALTH CLINIC IV	88.03	0	1,991	0		14.00
15.00	EMERGENCY	91.00	0	1,758	0		15.00
	TOTALS		0	795,770			
500.00	Grand Total: Decreases		1,500,963	1,132,563			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2024 9:32 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	41,382	0	41,382	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	0	0	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	7,548,063	184,762	0	184,762	0	5.00
6.00	Movable Equipment	15,552,260	2,061,116	0	2,061,116	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,168,535	2,287,260	0	2,287,260	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,168,535	2,287,260	0	2,287,260	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	236,907	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	7,732,825	0	5.00
6.00	Movable Equipment	17,613,376	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,455,795	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	39,455,795	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2024 9:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,502,728	0	566,167	0	0	1.00
3.00	Total (sum of lines 1-2)	1,502,728	0	566,167	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,068,895		1.00
3.00	Total (sum of lines 1-2)	0	2,068,895		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2024 9:32 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	NEW CAP REL COSTS-BLDG & FIXT	39,455,795	0	39,455,795	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	39,455,795	0	39,455,795	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,501,995	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,501,995	0	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	NEW CAP REL COSTS-BLDG & FIXT	553,659	61,504	0	0	2,117,158	1.00
3.00	Total (sum of lines 1-2)	553,659	61,504	0	0	2,117,158	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 9:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-1,560,620			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 9:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVEST INC/UNRESTRIC- INT EXP	B	-12,508	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	OTHER SERVICES -OTHER REV	B	-5,650	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CAFETERIA VENDING - OTHER REV	B	-58,559	DIETARY	10.00	0	33.02
33.03	REBATES & REFUNDS - OTHER REV	B	-15,660	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	MEDICAL RECORDS FEES -OTHER REV	B	-4,577	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.08	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	33.08
33.09	PHYSICIAN RECRUITMENT- ADMIN	A	-44,279	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSE	A	-3,946	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CRNA	A	-550,000	ANESTHESIOLOGY	53.00	0	33.11
33.12	HAF EXPENSE	A	-1,686,364	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	EHR DEPRECIATION ON 2012 PAYMENT	A	-733	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	RENTAL INCOME - KNOX	B	-13,092	RURAL HEALTH CLINIC IV	88.03	0	33.14
33.15	RENTAL INCOME - PHYSICIAN	B	-13,092	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,969,358				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2024 9:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	481,899	481,899	0	0	0	1.00
2.00	50.00	OPERATING ROOM	933,477	933,477	0	0	0	2.00
3.00	60.00	LABORATORY	9,230	0	9,230	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	5,434	5,434	0	0	0	4.00
5.00	76.00	ONCOLOGY	42,877	42,877	0	0	0	5.00
6.00	90.00	CLINIC	27,000	0	27,000	0	0	6.00
7.00	90.01	WOUND CARE	96,933	96,933	0	0	0	7.00
8.00	91.00	EMERGENCY	1,344,763	0	1,344,763	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,941,613	1,560,620	1,380,993		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.00	ONCOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	481,899		1.00
2.00	50.00	OPERATING ROOM	0	0	0	933,477		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,434		4.00
5.00	76.00	ONCOLOGY	0	0	0	42,877		5.00
6.00	90.00	CLINIC	0	0	0	0		6.00
7.00	90.01	WOUND CARE	0	0	0	96,933		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,560,620		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,117,158	2,117,158				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,701,723	25,366	5,727,089			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,099,770	416,980	915,429	7,432,179	7,432,179	5.00
7.00	00700	OPERATION OF PLANT	1,812,677	184,234	110,944	2,107,855	504,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,485	18,110	2,581	99,176	23,723	8.00
9.00	00900	HOUSEKEEPING	371,183	11,293	65,009	447,485	107,041	9.00
10.00	01000	DIETARY	363,300	88,884	65,003	517,187	123,714	10.00
13.00	01300	NURSING ADMINISTRATION	474,331	13,078	119,513	606,922	145,179	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,607	27,648	8,327	90,582	21,668	14.00
15.00	01500	PHARMACY	0	22,675	0	22,675	5,424	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	334,252	45,144	93,560	472,956	113,133	16.00
17.00	01700	SOCIAL SERVICE	53,584	0	15,450	69,034	16,513	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,659,917	260,567	574,736	2,495,220	596,869	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	749,172	160,272	455,608	1,365,052	326,527	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,182	907	0	8,089	1,935	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,327,920	140,816	293,279	1,762,015	421,483	54.00
60.00	06000	LABORATORY	1,599,102	40,639	225,650	1,865,391	446,211	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	51,349	1,785	0	53,134	12,710	63.00
65.00	06500	RESPIRATORY THERAPY	411,450	22,909	107,610	541,969	129,642	65.00
66.00	06600	PHYSICAL THERAPY	1,000,212	51,756	281,179	1,333,147	318,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,109	0	53,498	240,607	57,554	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	193	46	68.00
69.00	06900	ELECTROCARDIOLOGY	8,907	0	0	8,907	2,131	69.00
69.01	06901	CARDIAC REHABILITATION	76,115	13,107	21,017	110,239	26,370	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	670,039	0	0	670,039	160,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,676	0	0	79,676	19,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,505,156	0	24,304	2,529,460	605,059	73.00
76.00	03020	ONCOLOGY	153,604	16,501	42,753	212,858	50,917	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,845,594	235,025	1,314,060	6,394,679	1,529,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	773,522	0	187,880	961,402	229,972	88.01
88.02	08802	RURAL HEALTH CLINIC III	235,349	0	56,437	291,786	69,797	88.02
88.03	08803	RURAL HEALTH CLINIC IV	662,929	0	161,180	824,109	197,131	88.03
90.00	09000	CLINIC	263,511	53,102	19,105	335,718	80,305	90.00
90.01	09001	WOUND CARE	277,137	64,571	40,680	382,388	91,469	90.01
91.00	09100	EMERGENCY	2,753,924	188,594	361,353	3,303,871	790,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,760,139	2,103,963	5,616,145	37,636,000	7,224,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,195	0	13,195	3,156	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	414,049	0	62,902	476,951	114,089	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	21,369	0	0	21,369	5,112	192.02
192.03	19203	CULVER	268,774	0	43,610	312,384	74,724	192.03
194.00	07950	MARKETING	38,210	0	4,432	42,642	10,200	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,502,541	2,117,158	5,727,089	38,502,541	7,432,179	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,612,064					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,666	147,565				8.00
9.00	00900	HOUSEKEEPING	15,381	0	569,907			9.00
10.00	01000	DIETARY	121,060	0	27,706	789,667		10.00
13.00	01300	NURSING ADMINISTRATION	17,812	0	4,076	0	773,989	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,657	0	8,618	0	0	14.00
15.00	01500	PHARMACY	30,883	0	7,068	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,486	0	14,072	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	354,891	30,032	81,220	789,667	423,349	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	218,290	35,200	49,958	0	103,109	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,235	0	283	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	191,790	25,341	43,893	0	0	54.00
60.00	06000	LABORATORY	55,349	357	12,667	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,431	0	556	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	31,201	0	7,141	0	18,024	65.00
66.00	06600	PHYSICAL THERAPY	94,202	25,104	21,559	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	17,852	0	4,086	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	22,475	37	5,143	0	42,918	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	320,102	2,300	73,258	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	155,568	248	35,603	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	65,431	40	14,975	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	85,714	0	19,616	0	0	88.03
90.00	09000	CLINIC	72,325	0	16,552	0	19,880	90.00
90.01	09001	WOUND CARE	87,945	3,012	20,127	0	0	90.01
91.00	09100	EMERGENCY	256,863	25,430	58,785	0	166,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,342,609	147,101	526,962	789,667	773,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,972	0	4,113	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	251,483	378	38,832	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	0	86	0	0	0	192.03
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,612,064	147,565	569,907	789,667	773,989	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,525					14.00
15.00	01500	PHARMACY	0	66,050				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	661,647			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	85,547		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	14,276	79,837	4,865,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	58,033	5,710	2,161,879	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	7,134	0	18,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	167,984	0	2,612,506	54.00
60.00	06000	LABORATORY	0	0	130,109	0	2,510,084	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,182	0	70,013	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	9,064	0	737,041	65.00
66.00	06600	PHYSICAL THERAPY	0	0	27,649	0	1,820,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,030	0	304,191	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,631	0	16,669	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	3,092	0	161,639	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,238	0	22,183	0	992,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,287	0	3,373	0	120,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	66,050	81,033	0	3,281,602	73.00
76.00	03020	ONCOLOGY	0	0	2,178	0	336,526	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	44,850	0	8,364,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4,799	0	1,387,592	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	819	0	442,848	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	5,066	0	1,131,636	88.03
90.00	09000	CLINIC	0	0	2,795	0	527,575	90.00
90.01	09001	WOUND CARE	0	0	7,811	0	592,752	90.01
91.00	09100	EMERGENCY	0	0	56,556	0	4,658,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,525	66,050	661,647	85,547	37,115,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	38,436	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	881,733	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	26,481	192.02
192.03	19203	CULVER	0	0	0	0	387,194	192.03
194.00	07950	MARKETING	0	0	0	0	52,842	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	158,525	66,050	661,647	85,547	38,502,541	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,865,361		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,161,879		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	18,676		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,612,506		54.00
60.00	06000	LABORATORY	0	2,510,084		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	70,013		63.00
65.00	06500	RESPIRATORY THERAPY	0	737,041		65.00
66.00	06600	PHYSICAL THERAPY	0	1,820,556		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	304,191		67.00
68.00	06800	SPEECH PATHOLOGY	0	239		68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,669		69.00
69.01	06901	CARDIAC REHABILITATION	0	161,639		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	992,737		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,395		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,281,602		73.00
76.00	03020	ONCOLOGY	0	336,526		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	8,364,822		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,387,592		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	442,848		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,131,636		88.03
90.00	09000	CLINIC	0	527,575		90.00
90.01	09001	WOUND CARE	0	592,752		90.01
91.00	09100	EMERGENCY	0	4,658,516		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,115,855		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,436		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	881,733		192.00
192.01	19201	KNOX RHC	0	0		192.01
192.02	19202	RETAIL PHARMACY	0	26,481		192.02
192.03	19203	CULVER	0	387,194		192.03
194.00	07950	MARKETING	0	52,842		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	38,502,541		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,366	25,366	25,366		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	416,980	416,980	4,056	421,036	5.00
7.00	00700	OPERATION OF PLANT	0	184,234	184,234	492	28,564	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,110	18,110	11	1,344	8.00
9.00	00900	HOUSEKEEPING	0	11,293	11,293	288	6,064	9.00
10.00	01000	DIETARY	0	88,884	88,884	288	7,008	10.00
13.00	01300	NURSING ADMINISTRATION	0	13,078	13,078	530	8,224	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,648	27,648	37	1,227	14.00
15.00	01500	PHARMACY	0	22,675	22,675	0	307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,144	45,144	415	6,409	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	68	935	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	260,567	260,567	2,547	33,813	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	160,272	160,272	2,019	18,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	907	907	0	110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	140,816	140,816	1,299	23,877	54.00
60.00	06000	LABORATORY	0	40,639	40,639	1,000	25,278	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,785	1,785	0	720	63.00
65.00	06500	RESPIRATORY THERAPY	0	22,909	22,909	477	7,344	65.00
66.00	06600	PHYSICAL THERAPY	0	51,756	51,756	1,246	18,065	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	237	3,260	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	121	69.00
69.01	06901	CARDIAC REHABILITATION	0	13,107	13,107	93	1,494	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108	34,277	73.00
76.00	03020	ONCOLOGY	0	16,501	16,501	189	2,884	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	235,025	235,025	5,812	86,655	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	832	13,028	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	250	3,954	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	714	11,168	88.03
90.00	09000	CLINIC	0	53,102	53,102	85	4,549	90.00
90.01	09001	WOUND CARE	0	64,571	64,571	180	5,182	90.01
91.00	09100	EMERGENCY	0	188,594	188,594	1,601	44,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,103,963	2,103,963	24,874	409,293	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,195	13,195	0	179	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	279	6,463	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	290	192.02
192.03	19203	CULVER	0	0	0	193	4,233	192.03
194.00	07950	MARKETING	0	0	0	20	578	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,117,158	2,117,158	25,366	421,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	213,290					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,014	21,479				8.00
9.00	00900	HOUSEKEEPING	1,256	0	18,901			9.00
10.00	01000	DIETARY	9,885	0	919	106,984		10.00
13.00	01300	NURSING ADMINISTRATION	1,454	0	135	0	23,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,075	0	286	0	0	14.00
15.00	01500	PHARMACY	2,522	0	234	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,021	0	467	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,979	4,371	2,692	106,984	12,810	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,825	5,123	1,657	0	3,120	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	101	0	9	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,661	3,689	1,456	0	0	54.00
60.00	06000	LABORATORY	4,520	52	420	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	198	0	18	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,548	0	237	0	545	65.00
66.00	06600	PHYSICAL THERAPY	7,692	3,654	715	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,458	0	135	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,835	5	171	0	1,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,138	335	2,430	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,703	36	1,181	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,343	6	497	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,999	0	651	0	0	88.03
90.00	09000	CLINIC	5,906	0	549	0	602	90.00
90.01	09001	WOUND CARE	7,181	438	668	0	0	90.01
91.00	09100	EMERGENCY	20,974	3,702	1,950	0	5,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191,288	21,411	17,477	106,984	23,421	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,467	0	136	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,535	55	1,288	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	0	13	0	0	0	192.03
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	213,290	21,479	18,901	106,984	23,421	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,273					14.00
15.00	01500	PHARMACY	0	25,738				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	57,456			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,003		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,239	936	454,938	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	5,036	67	213,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	619	0	1,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,613	0	201,411	54.00
60.00	06000	LABORATORY	0	0	11,292	0	83,201	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	103	0	2,824	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	787	0	34,847	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,400	0	85,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	523	0	4,020	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	489	0	610	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	268	0	16,555	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,550	0	1,925	0	39,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,723	0	293	0	5,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,738	7,032	0	67,155	73.00
76.00	03020	ONCOLOGY	0	0	189	0	23,073	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,892	0	360,287	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	416	0	28,196	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	71	0	10,121	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	440	0	19,972	88.03
90.00	09000	CLINIC	0	0	243	0	65,036	90.00
90.01	09001	WOUND CARE	0	0	678	0	78,898	90.01
91.00	09100	EMERGENCY	0	0	4,908	0	271,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,273	25,738	57,456	1,003	2,068,234	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,977	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	28,620	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	290	192.02
192.03	19203	CULVER	0	0	0	0	4,439	192.03
194.00	07950	MARKETING	0	0	0	0	598	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,273	25,738	57,456	1,003	2,117,158	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	454,938		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	213,617		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,746		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	201,411		54.00
60.00	06000	LABORATORY	0	83,201		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,824		63.00
65.00	06500	RESPIRATORY THERAPY	0	34,847		65.00
66.00	06600	PHYSICAL THERAPY	0	85,528		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,020		67.00
68.00	06800	SPEECH PATHOLOGY	0	3		68.00
69.00	06900	ELECTROCARDIOLOGY	0	610		69.00
69.01	06901	CARDIAC REHABILITATION	0	16,555		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,555		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,096		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,155		73.00
76.00	03020	ONCOLOGY	0	23,073		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	360,287		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	28,196		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	10,121		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	19,972		88.03
90.00	09000	CLINIC	0	65,036		90.00
90.01	09001	WOUND CARE	0	78,898		90.01
91.00	09100	EMERGENCY	0	271,545		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,068,234		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,977		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,620		192.00
192.01	19201	KNOX RHC	0	0		192.01
192.02	19202	RETAIL PHARMACY	0	290		192.02
192.03	19203	CULVER	0	4,439		192.03
194.00	07950	MARKETING	0	598		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,117,158		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	72,363					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	867	19,855,557				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,252	3,173,746	-7,432,179	31,070,362		5.00
7.00	00700	OPERATION OF PLANT	6,297	384,638	0	2,107,855	65,550	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	619	8,949	0	99,176	619	8.00
9.00	00900	HOUSEKEEPING	386	225,382	0	447,485	386	9.00
10.00	01000	DIETARY	3,038	225,361	0	517,187	3,038	10.00
13.00	01300	NURSING ADMINISTRATION	447	414,344	0	606,922	447	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	945	28,870	0	90,582	945	14.00
15.00	01500	PHARMACY	775	0	0	22,675	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,543	324,369	0	472,956	1,543	16.00
17.00	01700	SOCIAL SERVICE	0	53,566	0	69,034	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,906	1,992,580	0	2,495,220	8,906	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,478	1,579,571	0	1,365,052	5,478	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	8,089	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	1,016,783	0	1,762,015	4,813	54.00
60.00	06000	LABORATORY	1,389	782,317	0	1,865,391	1,389	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61	0	0	53,134	61	63.00
65.00	06500	RESPIRATORY THERAPY	783	373,077	0	541,969	783	65.00
66.00	06600	PHYSICAL THERAPY	1,769	974,835	0	1,333,147	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	185,476	0	240,607	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	193	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,907	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	72,864	0	110,239	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	670,039	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,676	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,262	0	2,529,460	0	73.00
76.00	03020	ONCOLOGY	564	148,223	0	212,858	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,033	4,555,803	0	6,394,679	8,033	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	651,370	0	961,402	3,904	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	195,664	0	291,786	1,642	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	558,804	0	824,109	2,151	88.03
90.00	09000	CLINIC	1,815	66,235	0	335,718	1,815	90.00
90.01	09001	WOUND CARE	2,207	141,037	0	382,388	2,207	90.01
91.00	09100	EMERGENCY	6,446	1,252,793	0	3,303,871	6,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,912	19,470,919	-7,432,179	30,203,821	58,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	13,195	451	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	218,079	0	476,951	6,311	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	21,369	0	192.02
192.03	19203	CULVER	0	151,193	0	312,384	0	192.03
194.00	07950	MARKETING	0	15,366	0	42,642	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,117,158	5,727,089		7,432,179	2,612,064	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.257466	0.288438		0.239205	39.848421	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		25,366		421,036	213,290	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001278		0.013551	3.253852	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,175					8.00
9.00	00900	HOUSEKEEPING	0	62,492				9.00
10.00	01000	DIETARY	0	3,038	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	447	0	74,247		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	945	0	0	3,593,868	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,543	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,626	8,906	100	40,611	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,519	5,478	0	9,891	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	31	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,092	4,813	0	0	0	54.00
60.00	06000	LABORATORY	269	1,389	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	1,729	0	65.00
66.00	06600	PHYSICAL THERAPY	18,913	2,364	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,179,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	414,583	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	28	564	0	4,117	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,733	8,033	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	187	3,904	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	30	1,642	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,151	0	0	0	88.03
90.00	09000	CLINIC	0	1,815	0	1,907	0	90.00
90.01	09001	WOUND CARE	2,269	2,207	0	0	0	90.01
91.00	09100	EMERGENCY	19,159	6,446	0	15,992	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,825	57,783	100	74,247	3,593,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	285	4,258	0	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	65	0	0	0	0	192.03
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	147,565	569,907	789,667	773,989	158,525	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.327322	9.119679	7,896.670000	10.424515	0.044110	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,479	18,901	106,984	23,421	32,273	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.193200	0.302455	1,069.840000	0.315447	0.008980	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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 9:32 am

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	81,328,541			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,754,877	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,133,687	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	876,925	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,644,903	0		54.00
60.00	06000	LABORATORY	0	15,993,763	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	145,337	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,114,180	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,398,821	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	741,197	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	692,182	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	380,137	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,726,839	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	414,583	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	9,960,981	0		73.00
76.00	03020	ONCOLOGY	0	267,732	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	5,513,229	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	589,883	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	100,633	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	622,744	0		88.03
90.00	09000	CLINIC	0	343,570	0		90.00
90.01	09001	WOUND CARE	0	960,119	0		90.01
91.00	09100	EMERGENCY	0	6,952,219	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	81,328,541	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	KNOX RHC	0	0	0		192.01
192.02	19202	RETAIL PHARMACY	0	0	0		192.02
192.03	19203	CULVER	0	0	0		192.03
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	66,050	661,647	85,547		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	660.500000	0.008135	8.651598		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,738	57,456	1,003		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	257.380000	0.000706	0.101436		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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,865,361		4,865,361	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,161,879		2,161,879	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	18,676		18,676	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,612,506		2,612,506	0	0	54.00
60.00	06000	LABORATORY	2,510,084		2,510,084	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	70,013		70,013	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	737,041	0	737,041	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,820,556	0	1,820,556	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,191	0	304,191	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	239	0	239	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,669		16,669	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	161,639		161,639	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	992,737		992,737	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,395		120,395	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,281,602		3,281,602	0	0	73.00
76.00	03020	ONCOLOGY	336,526		336,526	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,364,822		8,364,822	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,387,592		1,387,592	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	442,848		442,848	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,131,636		1,131,636	0	0	88.03
90.00	09000	CLINIC	527,575		527,575	0	0	90.00
90.01	09001	WOUND CARE	592,752		592,752	0	0	90.01
91.00	09100	EMERGENCY	4,658,516		4,658,516	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,691,814		1,691,814		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	38,807,669	0	38,807,669	0	0	200.00
201.00		Less Observation Beds	1,691,814		1,691,814		0	201.00
202.00		Total (see instructions)	37,115,855	0	37,115,855	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,129,113		1,129,113			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	543,586	6,590,101	7,133,687	0.303052	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	29,279	847,646	876,925	0.021297	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,150,208	19,494,695	20,644,903	0.126545	0.000000	54.00
60.00	06000	LABORATORY	1,725,492	14,268,271	15,993,763	0.156941	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,210	104,127	145,337	0.481729	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	510,530	603,650	1,114,180	0.661510	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	362,024	3,036,797	3,398,821	0.535643	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,143	537,054	741,197	0.410405	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,504	673,678	692,182	0.024082	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	380,137	380,137	0.425212	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	774,472	1,952,367	2,726,839	0.364061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,176	350,407	414,583	0.290400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,085,897	4,875,084	9,960,981	0.329446	0.000000	73.00
76.00	03020	ONCOLOGY	564	267,168	267,732	1.256951	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,513,229	5,513,229			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	589,883	589,883			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	100,633	100,633			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	622,744	622,744			88.03
90.00	09000	CLINIC	0	343,570	343,570	1.535568	0.000000	90.00
90.01	09001	WOUND CARE	2,391	957,728	960,119	0.617373	0.000000	90.01
91.00	09100	EMERGENCY	309,289	6,642,930	6,952,219	0.670076	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	625,764	625,764	2.703598	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,950,878	69,377,663	81,328,541			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,950,878	69,377,663	81,328,541			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,865,361		4,865,361	0	4,865,361	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,161,879		2,161,879	0	2,161,879	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	18,676		18,676	0	18,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,612,506		2,612,506	0	2,612,506	54.00
60.00	06000	LABORATORY	2,510,084		2,510,084	0	2,510,084	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	70,013		70,013	0	70,013	63.00
65.00	06500	RESPIRATORY THERAPY	737,041	0	737,041	0	737,041	65.00
66.00	06600	PHYSICAL THERAPY	1,820,556	0	1,820,556	0	1,820,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,191	0	304,191	0	304,191	67.00
68.00	06800	SPEECH PATHOLOGY	239	0	239	0	239	68.00
69.00	06900	ELECTROCARDIOLOGY	16,669		16,669	0	16,669	69.00
69.01	06901	CARDIAC REHABILITATION	161,639		161,639	0	161,639	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	992,737		992,737	0	992,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,395		120,395	0	120,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,281,602		3,281,602	0	3,281,602	73.00
76.00	03020	ONCOLOGY	336,526		336,526	0	336,526	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,364,822		8,364,822	0	8,364,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,387,592		1,387,592	0	1,387,592	88.01
88.02	08802	RURAL HEALTH CLINIC III	442,848		442,848	0	442,848	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,131,636		1,131,636	0	1,131,636	88.03
90.00	09000	CLINIC	527,575		527,575	0	527,575	90.00
90.01	09001	WOUND CARE	592,752		592,752	0	592,752	90.01
91.00	09100	EMERGENCY	4,658,516		4,658,516	0	4,658,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,691,814		1,691,814		1,691,814	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	38,807,669	0	38,807,669	0	38,807,669	200.00
201.00		Less Observation Beds	1,691,814		1,691,814		1,691,814	201.00
202.00		Total (see instructions)	37,115,855	0	37,115,855	0	37,115,855	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 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	1,129,113		1,129,113			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	543,586	6,590,101	7,133,687	0.303052	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	29,279	847,646	876,925	0.021297	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,150,208	19,494,695	20,644,903	0.126545	0.000000	54.00
60.00	06000	LABORATORY	1,725,492	14,268,271	15,993,763	0.156941	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,210	104,127	145,337	0.481729	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	510,530	603,650	1,114,180	0.661510	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	362,024	3,036,797	3,398,821	0.535643	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,143	537,054	741,197	0.410405	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,504	673,678	692,182	0.024082	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	380,137	380,137	0.425212	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	774,472	1,952,367	2,726,839	0.364061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,176	350,407	414,583	0.290400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,085,897	4,875,084	9,960,981	0.329446	0.000000	73.00
76.00	03020	ONCOLOGY	564	267,168	267,732	1.256951	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,513,229	5,513,229	1.517227	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	589,883	589,883	2.352317	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	100,633	100,633	4.400624	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	622,744	622,744	1.817177	0.000000	88.03
90.00	09000	CLINIC	0	343,570	343,570	1.535568	0.000000	90.00
90.01	09001	WOUND CARE	2,391	957,728	960,119	0.617373	0.000000	90.01
91.00	09100	EMERGENCY	309,289	6,642,930	6,952,219	0.670076	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	625,764	625,764	2.703598	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,950,878	69,377,663	81,328,541			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,950,878	69,377,663	81,328,541			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		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 ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213,617	7,133,687	0.029945	102,626	3,073	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,746	876,925	0.001991	9,644	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,411	20,644,903	0.009756	209,854	2,047	54.00
60.00	06000	LABORATORY	83,201	15,993,763	0.005202	328,057	1,707	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,824	145,337	0.019431	23,315	453	63.00
65.00	06500	RESPIRATORY THERAPY	34,847	1,114,180	0.031276	179,082	5,601	65.00
66.00	06600	PHYSICAL THERAPY	85,528	3,398,821	0.025164	49,657	1,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,020	741,197	0.005424	34,444	187	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	610	692,182	0.000881	10,782	9	69.00
69.01	06901	CARDIAC REHABILITATION	16,555	380,137	0.043550	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,555	2,726,839	0.014506	128,918	1,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,096	414,583	0.012292	7,043	87	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,155	9,960,981	0.006742	445,085	3,001	73.00
76.00	03020	ONCOLOGY	23,073	267,732	0.086179	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	360,287	5,513,229	0.065350	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	28,196	589,883	0.047799	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,121	100,633	0.100573	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	19,972	622,744	0.032071	0	0	88.03
90.00	09000	CLINIC	65,036	343,570	0.189295	0	0	90.00
90.01	09001	WOUND CARE	78,898	960,119	0.082175	0	0	90.01
91.00	09100	EMERGENCY	271,545	6,952,219	0.039059	59,551	2,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	158,193	625,764	0.252800	0	0	92.00
200.00		Total (lines 50 through 199)	1,771,489	80,199,428		1,588,058	21,630	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,133,687	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	876,925	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,644,903	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,993,763	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	145,337	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,114,180	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,398,821	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	741,197	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	692,182	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	380,137	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,726,839	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	414,583	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,960,981	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	267,732	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,513,229	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	589,883	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	100,633	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	622,744	0.000000	88.03
90.00	09000	CLINIC	0	0	0	343,570	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	960,119	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,952,219	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	625,764	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	80,199,428		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	102,626	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	9,644	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	209,854	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	328,057	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	23,315	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	179,082	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,657	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,444	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,782	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	128,918	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,043	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	445,085	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	59,551	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,588,058	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.303052	0	1,562,275	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021297	0	201,752	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126545	0	5,254,361	0	0	54.00
60.00	06000	LABORATORY	0.156941	0	4,427,285	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.481729	0	45,393	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.661510	0	138,848	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.535643	0	1,029,469	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410405	0	107,955	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024082	0	232,056	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.425212	0	167,740	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364061	0	626,978	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290400	0	78,902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329446	0	3,600,733	2,031	0	73.00
76.00	03020	ONCOLOGY	1.256951	0	112,300	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	1.535568	0	180,560	0	0	90.00
90.01	09001	WOUND CARE	0.617373	0	251,228	0	0	90.01
91.00	09100	EMERGENCY	0.670076	0	1,642,603	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.703598	0	197,315	0	0	92.00
200.00		Subtotal (see instructions)		0	19,857,753	2,031	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	19,857,753	2,031	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	473,451	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,297	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	664,913	0	54.00
60.00	06000	LABORATORY	694,823	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,867	0	63.00
65.00	06500	RESPIRATORY THERAPY	91,849	0	65.00
66.00	06600	PHYSICAL THERAPY	551,428	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,305	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,588	0	69.00
69.01	06901	CARDIAC REHABILITATION	71,325	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,258	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,913	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,186,247	669	73.00
76.00	03020	ONCOLOGY	141,156	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	277,262	0	90.00
90.01	09001	WOUND CARE	155,101	0	90.01
91.00	09100	EMERGENCY	1,100,669	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	533,460	0	92.00
200.00		Subtotal (see instructions)	6,268,912	669	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,268,912	669	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,947	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,425	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)	801	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	147	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)	206	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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)	154	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	345	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)	147	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)	206	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,865,361	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)	3,757	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)	41,013	25.00
26.00	Total swing-bed cost (see instructions)	1,001,838	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,863,523	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,863,523	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)	2,711.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	935,378	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)	935,378	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	515,553	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)	1,450,931	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)	398,552	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	558,515	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	957,067	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)	624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,711.24	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,691,814	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	454,938	4,865,361	0.093505	1,691,814	158,193	90.00
91.00	Nursing Program cost	0	4,865,361	0.000000	1,691,814	0	91.00
92.00	Allied health cost	0	4,865,361	0.000000	1,691,814	0	92.00
93.00	All other Medical Education	0	4,865,361	0.000000	1,691,814	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 9:32 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,947	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,425	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)	801	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	125	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)	228	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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)	154	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,865,361	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)	965,956	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,899,405	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,899,405	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)	2,736.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,419	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)	16,419	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 9:32 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)	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)	15,062	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)	31,481	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)	624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,736.42	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 9:32 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,707,526	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	454,938	4,865,361	0.093505	1,707,526	159,662	90.00
91.00	Nursing Program cost	0	4,865,361	0.000000	1,707,526	0	91.00
92.00	Allied health cost	0	4,865,361	0.000000	1,707,526	0	92.00
93.00	All other Medical Education	0	4,865,361	0.000000	1,707,526	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		408,668		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.303052	102,626	31,101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021297	9,644	205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126545	209,854	26,556	54.00
60.00	06000	LABORATORY	0.156941	328,057	51,486	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.481729	23,315	11,232	63.00
65.00	06500	RESPIRATORY THERAPY	0.661510	179,082	118,465	65.00
66.00	06600	PHYSICAL THERAPY	0.535643	49,657	26,598	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410405	34,444	14,136	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024082	10,782	260	69.00
69.01	06901	CARDIAC REHABILITATION	0.425212	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364061	128,918	46,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290400	7,043	2,045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329446	445,085	146,631	73.00
76.00	03020	ONCOLOGY	1.256951	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.535568	0	0	90.00
90.01	09001	WOUND CARE	0.617373	0	0	90.01
91.00	09100	EMERGENCY	0.670076	59,551	39,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.703598	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,588,058	515,553	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)		1,588,058		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.303052	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021297	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126545	32,619	4,128	54.00
60.00	06000	LABORATORY	0.156941	73,521	11,538	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.481729	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.661510	19,559	12,938	65.00
66.00	06600	PHYSICAL THERAPY	0.535643	130,296	69,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410405	61,187	25,111	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024082	1,609	39	69.00
69.01	06901	CARDIAC REHABILITATION	0.425212	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364061	42,837	15,595	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290400	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329446	83,394	27,474	73.00
76.00	03020	ONCOLOGY	1.256951	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.535568	0	0	90.00
90.01	09001	WOUND CARE	0.617373	0	0	90.01
91.00	09100	EMERGENCY	0.670076	14,597	9,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.703598	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		459,619	176,396	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)		459,619		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 9:32 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		5,349		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.303052	5,047	1,530	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021297	389	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126545	13,609	1,722	54.00
60.00	06000	LABORATORY	0.156941	8,633	1,355	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.481729	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.661510	1,438	951	65.00
66.00	06600	PHYSICAL THERAPY	0.535643	409	219	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410405	122	50	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024082	67	2	69.00
69.01	06901	CARDIAC REHABILITATION	0.425212	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364061	3,212	1,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290400	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329446	14,136	4,657	73.00
76.00	03020	ONCOLOGY	1.256951	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.517227	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.352317	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4.400624	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.817177	0	0	88.03
90.00	09000	CLINIC	1.535568	0	0	90.00
90.01	09001	WOUND CARE	0.617373	0	0	90.01
91.00	09100	EMERGENCY	0.670076	5,073	3,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.703598	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		52,135	15,062	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)		52,135		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 2/27/2024 9:32 am

Title XIX | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,269,581	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs 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)	6,269,581	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,332,277	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	64,275	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,104,129	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,163,873	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	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)	3,163,873	30.00
31.00	Primary payer payments	6,262	31.00
32.00	Subtotal (line 30 minus line 31)	3,157,611	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)	393,216	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	255,590	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	201,474	36.00
37.00	Subtotal (see instructions)	3,413,201	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,413,201	40.00
40.01	Sequestration adjustment (see instructions)	68,264	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,826,834	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)	-481,897	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	Hospital	Cost

		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: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,159,302		3,756,234	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	01/24/2023	70,600	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		70,600	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)		1,159,302		3,826,834	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		168,636		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		481,897	6.02
7.00	Total Medicare program liability (see instructions)		1,327,938		3,344,937	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,028,858		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)		1,028,858		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		81,172		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,110,030		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	966,638	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	178,160	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	353	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,144,798	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,144,798	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,144,798	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,114	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,132,684	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,132,684	0	19.00
19.01	Sequestration adjustment (see instructions)	22,654	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,028,858	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	81,172	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/27/2024 9:32 am

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,450,931	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,450,931	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,465,440	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,465,440	19.00
20.00	Deductibles (exclude professional component)	125,023	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,340,417	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,340,417	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,496	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,622	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,352	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,355,039	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,355,039	30.00
30.01	Sequestration adjustment (see instructions)	27,101	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,159,302	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	168,636	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 9:32 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	31,481		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)	31,481	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)	31,481	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,349		8.00
9.00	Ancillary service charges	52,135	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)	57,484	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)	57,484	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,003	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)	31,481	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)	31,481	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)	31,481	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)	31,481	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	31,481	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)	31,481	0	40.00
41.00	Interim payments	22,582	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	8,899	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/27/2024 9:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,140,259	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,712,483	0	0	0	4.00
5.00	Other receivable	224,696	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,603,809	0	0	0	6.00
7.00	Inventory	662,953	0	0	0	7.00
8.00	Prepaid expenses	46,544	0	0	0	8.00
9.00	Other current assets	4,167,290	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)	11,350,416	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	236,907	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-457,469	0	0	0	14.00
15.00	Buildings	13,253,038	0	0	0	15.00
16.00	Accumulated depreciation	-9,662,204	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-207,105	0	0	0	18.00
19.00	Fixed equipment	7,732,825	0	0	0	19.00
20.00	Accumulated depreciation	-7,698,063	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	17,613,376	0	0	0	23.00
24.00	Accumulated depreciation	-9,528,874	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)	11,902,080	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,435,441	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,435,441	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,687,937	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,445,767	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,227,259	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	893,449	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,005,555	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,572,030	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,236,419	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-1,859,304	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,377,115	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,949,145	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	26,738,792				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)	26,738,792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,687,937	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/27/2024 9:32 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		24,557,749		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,181,043				2.00
3.00	Total (sum of line 1 and line 2)		26,738,792		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,738,792		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,738,792		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/27/2024 9:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,236,613		1,236,613	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	131,245		131,245	5.00
6.00	Swing bed - NF	62,834		62,834	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,430,692		1,430,692	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,430,692		1,430,692	17.00
18.00	Ancillary services	10,027,798	55,164,706	65,192,504	18.00
19.00	Outpatient services	309,289	7,612,264	7,921,553	19.00
20.00	RURAL HEALTH CLINIC	0	5,513,229	5,513,229	20.00
20.01	RURAL HEALTH CLINIC II	0	589,883	589,883	20.01
20.02	RURAL HEALTH CLINIC III	0	100,633	100,633	20.02
20.03	RURAL HEALTH CLINIC IV	0	622,744	622,744	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON-PROVIDER BASED	0	193,332	193,332	27.00
27.01	PHYSICIAN FEES	292,416	121,519	413,935	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,060,195	69,918,310	81,978,505	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,471,899		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)		42,471,899		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/27/2024 9:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,978,505	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,161,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,817,192	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,471,899	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,654,707	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,695,087	24.00
24.01	RENTAL INCOME	22,641	24.01
24.02	NON OPERATING	145,071	24.02
24.50	COVID-19 PHE Funding	-27,049	24.50
25.00	Total other income (sum of lines 6-24)	6,835,750	25.00
26.00	Total (line 5 plus line 25)	2,181,043	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)	2,181,043	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,189,920	24,000	3,213,920	-1,188,942	2,024,978	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	967,902	54,200	1,022,102	-11,354	1,010,748	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	232,512	0	232,512	0	232,512	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	54,149	0	54,149	-26,004	28,145	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	755,163	0	755,163	0	755,163	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,199,646	78,200	5,277,846	-1,226,300	4,051,546	10.00
11.00	Physician Services Under Agreement	0	0	0	-29,345	-29,345	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	-29,345	-29,345	14.00
15.00	Medical Supplies	0	41,817	41,817	-8,000	33,817	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	41,817	41,817	-8,000	33,817	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,199,646	120,017	5,319,663	-1,263,645	4,056,018	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	23,706	23,706	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	23,706	23,706	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	168,292	168,292	-7,842	160,450	29.00
30.00	Administrative Costs	726,519	182,181	908,700	-303,280	605,420	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	726,519	350,473	1,076,992	-311,122	765,870	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,926,165	470,490	6,396,655	-1,551,061	4,845,594	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 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	2,024,978		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,010,748		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	232,512		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	28,145		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	755,163		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,051,546		10.00
11.00	Physician Services Under Agreement	0	-29,345		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	-29,345		14.00
15.00	Medical Supplies	0	33,817		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	33,817		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,056,018		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	23,706		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	23,706		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	160,450		29.00
30.00	Administrative Costs	0	605,420		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	765,870		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,845,594		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305
Component CCN: 15-8527
Period: From 10/01/2022 To 09/30/2023
Worksheet M-1
Date/Time Prepared: 2/27/2024 9:32 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	371,222	36,000	407,222	88,635	495,857	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	-34,730	-34,730	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	93,416	0	93,416	0	93,416	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	26,004	26,004	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	25,979	0	25,979	0	25,979	9.00
10.00	Subtotal (sum of lines 1 through 9)	490,617	36,000	526,617	79,909	606,526	10.00
11.00	Physician Services Under Agreement	0	0	0	12,392	12,392	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	12,392	12,392	14.00
15.00	Medical Supplies	0	12,040	12,040	3,378	15,418	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	12,040	12,040	3,378	15,418	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	490,617	48,040	538,657	95,679	634,336	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	30,125	30,125	3,311	33,436	29.00
30.00	Administrative Costs	80,844	21,574	102,418	3,332	105,750	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	80,844	51,699	132,543	6,643	139,186	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	571,461	99,739	671,200	102,322	773,522	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 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	495,857		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	-34,730		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	93,416		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	26,004		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	25,979		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	606,526		10.00
11.00	Physician Services Under Agreement	0	12,392		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	12,392		14.00
15.00	Medical Supplies	0	15,418		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	15,418		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	634,336		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	33,436		29.00
30.00	Administrative Costs	0	105,750		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	139,186		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	773,522		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	26,002	26,002	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	78,442	10,000	88,442	31,663	120,105	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	29,140	0	29,140	0	29,140	9.00
10.00	Subtotal (sum of lines 1 through 9)	107,582	10,000	117,582	57,665	175,247	10.00
11.00	Physician Services Under Agreement	0	0	0	4,220	4,220	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	4,220	4,220	14.00
15.00	Medical Supplies	0	4,329	4,329	1,150	5,479	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	4,329	4,329	1,150	5,479	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	107,582	14,329	121,911	63,035	184,946	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	3,067	3,067	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	3,067	3,067	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,707	6,707	1,128	7,835	29.00
30.00	Administrative Costs	27,350	11,016	38,366	1,135	39,501	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,350	17,723	45,073	2,263	47,336	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	134,932	32,052	166,984	68,365	235,349	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	26,002		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	120,105		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	29,140		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	175,247		10.00
11.00	Physician Services Under Agreement	0	4,220		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	4,220		14.00
15.00	Medical Supplies	0	5,479		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	5,479		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	184,946		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	3,067		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	3,067		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,835		29.00
30.00	Administrative Costs	0	39,501		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	47,336		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	235,349		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 am

RHC IV | 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	320,262	15,000	335,262	27,648	362,910	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	121,228	12,000	133,228	0	133,228	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	60,366	0	60,366	0	60,366	9.00
10.00	Subtotal (sum of lines 1 through 9)	501,856	27,000	528,856	27,648	556,504	10.00
11.00	Physician Services Under Agreement	0	0	0	12,733	12,733	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	12,733	12,733	14.00
15.00	Medical Supplies	0	0	0	3,471	3,471	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	3,471	3,471	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	501,856	27,000	528,856	43,852	572,708	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	44,761	44,761	1,413	46,174	29.00
30.00	Administrative Costs	29,300	24,415	53,715	3,424	57,139	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	29,300	69,176	98,476	4,837	103,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	531,156	96,176	627,332	48,689	676,021	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 9:32 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	362,910		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	133,228		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	60,366		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	556,504		10.00
11.00	Physician Services Under Agreement	0	12,733		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	12,733		14.00
15.00	Medical Supplies	0	3,471		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	3,471		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	572,708		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-13,092	33,082		29.00
30.00	Administrative Costs	0	57,139		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-13,092	90,221		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,092	662,929		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 Component CCN: 15-8512

Period: From 10/01/2022 To 09/30/2023

Worksheet M-2

Date/Time Prepared: 2/27/2024 9:32 am

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	5.77	15,901	4,200	24,234		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.74	7,517	2,100	3,654		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.51	23,418		27,888	27,888	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	1.81	1,565			1,565	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)	9.32	24,983			29,453	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)					4,056,018	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					23,706	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,079,724	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994189	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					765,870	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,519,228	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,285,098	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,285,098	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,260,197	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,316,215	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 Component CCN: 15-8527

Period: From 10/01/2022 To 09/30/2023

Worksheet M-2

Date/Time Prepared: 2/27/2024 9:32 am

RHC II

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.74	1,529	4,200	3,108		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.45	2,755	2,100	3,045		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.19	4,284		6,153	6,153	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	0.37	68			68	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)	2.56	4,352			6,221	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)					634,336	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					634,336	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					139,186	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					614,070	15.00
16.00	Total overhead (sum of lines 14 and 15)					753,256	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					753,256	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					753,256	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,387,592	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 Component CCN: 15-8528

Period: From 10/01/2022 To 09/30/2023

Worksheet M-2 Date/Time Prepared: 2/27/2024 9:32 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	133	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.69	1,349	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.73	1,482		1	1,482	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)	0.73	1,482			1,482	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)					184,946	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,067	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					188,013	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.983687	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					47,336	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					207,499	15.00
16.00	Total overhead (sum of lines 14 and 15)					254,835	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					254,835	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					250,678	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					435,624	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/27/2024 9:32 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.96	2,454	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.87	2,018	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.83	4,472		2	4,472	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)	1.83	4,472			4,472	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)					572,708	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					572,708	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					90,221	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					468,707	15.00
16.00	Total overhead (sum of lines 14 and 15)					558,928	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					558,928	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					558,928	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,131,636	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 9:32 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)		8,316,215	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		186,748	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		8,129,467	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		29,453	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		29,453	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		276.01	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	232.77	246.69	8.00
9.00	Rate for Program covered visits (see instructions)	232.77	246.69	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,272	4,348	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	296,083	1,072,608	11.00
12.00	Program covered visits for mental health services (from contractor records)	14	29	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	3,259	7,154	13.00
14.00	Limit adjustment for mental health services (see instructions)	3,259	7,154	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	1,379,104	16.00
16.01	Total program charges (see instructions)(from contractor's records)		785,653	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		41,269	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		72,442	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.)		965,285	16.04
16.05	Total program cost (see instructions)	0	1,037,727	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		100,056	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		128,824	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,037,727	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		72,292	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,110,019	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,110,019	26.00
26.01	Sequestration adjustment (see instructions)		22,200	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,017,421	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)		70,398	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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 9:32 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)			1,387,592	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			57,720	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,329,872	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,221	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)			6,221	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			213.77	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	188.36	199.63		8.00
9.00	Rate for Program covered visits (see instructions)	188.36	199.63		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	425	856		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	80,053	170,883		11.00
12.00	Program covered visits for mental health services (from contractor records)	7	9		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,319	1,797		13.00
14.00	Limit adjustment for mental health services (see instructions)	1,319	1,797		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	254,052		16.00
16.01	Total program charges (see instructions)(from contractor's records)		164,191		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,692		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,260		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.)		171,169		16.04
16.05	Total program cost (see instructions)	0	178,429		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,831		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,334		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		178,429		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		26,638		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		205,067		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)		205,067		26.00
26.01	Sequestration adjustment (see instructions)		4,101		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		175,807		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)		25,159		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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			435,624	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			16,547	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			419,077	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,482	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,482	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			282.78	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	306.89	325.24		8.00
9.00	Rate for Program covered visits (see instructions)	282.78	282.78		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	84	279		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	23,754	78,896		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	102,650		16.00
16.01	Total program charges (see instructions)(from contractor's records)		44,940		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,194		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,296		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.)		70,429		16.04
16.05	Total program cost (see instructions)	0	77,725		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,318		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,886		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		77,725		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,389		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		84,114		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)		84,114		26.00
26.01	Sequestration adjustment (see instructions)		1,682		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		87,295		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)		-4,863		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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 9:32 am
	Title XVIII	RHC IV	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)			1,131,636	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			9,148	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,122,488	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,472	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)			4,472	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			251.00	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	203.35	215.51		8.00
9.00	Rate for Program covered visits (see instructions)	203.35	215.51		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	270	777		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	54,905	167,451		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	216		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	216		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	222,572		16.00
16.01	Total program charges (see instructions)(from contractor's records)		133,516		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,050		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,419		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.)		155,351		16.04
16.05	Total program cost (see instructions)	0	168,770		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,964		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,071		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		168,770		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,892		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		172,662		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)		172,662		26.00
26.01	Sequestration adjustment (see instructions)		3,453		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		165,513		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)		3,696		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: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 9:32 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)	4,051,546	4,051,546	4,051,546	4,051,546	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000432	0.001922	0.001045	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,750	7,787	4,234	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	23,670	22,320	31,320	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	25,420	30,107	35,554	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,056,018	4,056,018	4,056,018	4,056,018	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,260,197	4,260,197	4,260,197	4,260,197	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006267	0.007423	0.008766	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26,699	31,623	37,345	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	52,119	61,730	72,899	0	10.00
11.00	Total number of injections/infusions (from your records)	108	480	261	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	482.58	128.60	279.31	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	17	216	130	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8,204	27,778	36,310	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)		186,748	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)		72,292	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 9:32 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)	606,526	606,526	606,526	606,526	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000350	0.008256	0.003173	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	212	5,007	1,925	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,903	6,180	11,160	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,115	11,187	13,085	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	634,336	634,336	634,336	634,336	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	753,256	753,256	753,256	753,256	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003334	0.017636	0.020628	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,511	13,284	15,538	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,626	24,471	28,623	0	10.00
11.00	Total number of injections/infusions (from your records)	28	242	93	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	165.21	101.12	307.77	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	10	101	48	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,652	10,213	14,773	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)		57,720	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		26,638	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	175,247	175,247	175,247	175,247	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002111	0.005054	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	370	886	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,668	2,101	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,038	2,987	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	184,946	184,946	184,946	184,946	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	250,678	250,678	250,678	250,678	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.021833	0.016151	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,473	4,049	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9,511	7,036	0	0	10.00
11.00	Total number of injections/infusions (from your records)	15	49	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	634.07	143.59	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	18	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)	3,804	2,585	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)		16,547	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6,389	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 9:32 am

Title XVIII | RHC IV | 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)	556,504	556,504	556,504	556,504	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000063	0.002222	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	35	1,237	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	489	2,869	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	524	4,106	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	572,708	572,708	572,708	572,708	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	558,928	558,928	558,928	558,928	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000915	0.007169	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	511	4,007	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,035	8,113	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	71	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	517.50	114.27	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	25	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,035	2,857	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)		9,148	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)		3,892	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 9:32 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		1,017,421	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,017,421	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		70,398	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,087,819	7.00

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

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

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/27/2024 9:32 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		175,807	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)		175,807	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		25,159	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		200,966	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 9:32 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		87,295	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)		87,295	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		4,863	6.02
7.00	Total Medicare program liability (see instructions)		82,432	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 9:32 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		165,513	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)		165,513	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		3,696	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		169,209	7.00

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