

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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 10:24 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/29/2024	Time: 10:24 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 SCHNECK MEDICAL CENTER (15-0065) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Debbie Mann	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Debbie Mann		2
3	Signatory Title	VICE PRESIDENT OF FINANCE/CFO		3
4	Date	(Dated when report is electronic)		4

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	550,698	39,684	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	-1	0	0	0 5.00
6.00	SWING BED - NF	0			0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	1	0	0 9.00
10.00	RHC I JACKSON	0		43,223	0	0 10.00
10.01	RHC II BROWSTOWN	0		5,560	0	0 10.01
10.02	RHC III OBGYN	0		123	0	0 10.02
10.03	RHC IV URGENT CARE	0		44,757	0	0 10.03
10.04	RHC V SPC IM PEDS	0		43,021	0	0 10.04
10.05	RHC VI JENNINGS	0		35,861	0	0 10.05
10.06	RHC VII SCOTT	0		12,752	0	0 10.06
10.07	RHC VIII WASHINGTON CO	0		48,755	0	0 10.07
200.00	TOTAL	0	550,697	273,737	0	0 200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 10:24 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
Street: 411 WEST TIPTON STREET		PO Box:	State: IN	Zip Code: 47274-
City: SEYMOUR		County: JACKSON		

	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	SCHNECK MEDICAL CENTER	150065	99915	1	07/16/1966	N	P	0	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	SCHNECK MEDICAL CENTER	15U065	99915		03/04/1999	N	P	N	7.00
8.00	Swing Beds - NF	SCHNECK MEDICAL CENTER	15U065	99915		03/04/1999	N		0	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	JACKSON COUNTY HOME HEALTH	157155	99915		07/01/1985	N	P	0	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF MEMORIAL HOSPITAL	151529	99915		12/09/1994				14.00
15.00	Hospital-Based Health Clinic - RHC	JACKSON PARK	158564	99915		04/06/2022	N	0	0	15.00
15.01	Hospital-Based Health Clinic - RHC II	BROWNSTOWN	158565	99915		04/21/2022	N	0	0	15.01
15.02	Hospital-Based Health Clinic - RHC III	SCHNECK OBGYN	158566	99915		04/22/2022	N	0	0	15.02
15.03	Hospital-Based Health Clinic - RHC IV	SCHNECK URGENT CARE	158568	99915		05/11/2022	N	0	0	15.03
15.04	Hospital-Based Health Clinic - RHC V	SCHNECK PMC-IM-PED	158569	99915		05/06/2022	N	0	0	15.04
15.05	Hospital-Based Health Clinic - RHC VI	SFC JENNINGS	158575	99915		10/20/2023	N	0	0	15.05
15.06	Hospital-Based Health Clinic - RHC VII	SFC SCOTT	158574	99915		12/04/2023	N	0	0	15.06
15.07	Hospital-Based Health Clinic - RHC VIII	SFC WASHINGTON COUNTY	158578	99915		09/22/2023	N	0	0	15.07
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	8		21.00
		1.00	2.00	3.00

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

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		1.00	2.00	3.00			
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.			3	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.	2,310	447	0	5	909	122
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	
		Urban/Rural S		Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0		35.00
		Beginning:		Ending:			
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N		Y/N			
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)			N	N		40.00

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		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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
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 Criteria 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
61.01	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

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

					1.00	
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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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
1.00						
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 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

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			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		N		0 88.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00			0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	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. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)				107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 10:24 am	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
					1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00
					1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				N		112.00
					1.00	2.00	3.00
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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1		118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,553,491		0		0	
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N		118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				Y	N	123.00
Certified Transplant Center Information							
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 10:24 am	
		1.00	2.00				
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
1.00							
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
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							
Multi campus							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 10:24 am
			1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
			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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 10:24 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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)	N			N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2024		Y	04/01/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 10:24 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA		GERBER	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.	502-992-3500		LGERBER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0065

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2024 10:24 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER	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: 15-0065

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2024 10:24 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	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	34	12,410	0.00	0	1.00	
2.00 HMO and other (see instructions)						2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		34	12,410	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	18	6,570	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)		52	18,980	0.00	0	14.00	
15.00 CAH visits					0	15.00	
15.10 REH hours and visits				0.00	0	15.10	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY	101.00				0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE	116.00	2	730			24.00	
24.10 HOSPICE (non-distinct part)	30.00					24.10	
25.00 CMHC - CMHC						25.00	
26.00 RHC I JACKSON	88.00				0	26.00	
26.01 RHC II BROWSTOWN	88.01				0	26.01	
26.02 RHC III OBGYN	88.02				0	26.02	
26.03 RHC IV URGENT CARE	88.03				0	26.03	
26.04 RHC V SPC IM PEDS	88.04				0	26.04	
26.05 RHC VI JENNINGS	88.05				0	26.05	
26.06 RHC VII SCOTT	88.06				0	26.06	
26.07 RHC VIII WASHINGTON CO	88.07				0	26.07	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25	
27.00 Total (sum of lines 14-26)		54			0	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: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 10:24 am	
Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,202	1,527	5,147			1.00
2.00	HMO and other (see instructions)	548	316				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	12	0	60			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,214	1,527	5,207			7.00
8.00	INTENSIVE CARE UNIT	375	209	1,894			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		1,619	2,567			13.00
14.00	Total (see instructions)	1,589	3,355	9,668	0.00	781.87	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,988	0	8,480	0.00	17.14	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	137	0	179	0.00	9.26	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC I JACKSON	1,296	1,220	8,817	0.00	15.56	26.00
26.01	RHC II BROWSTOWN	912	285	4,626	0.00	4.84	26.01
26.02	RHC III OBGYN	236	1,605	4,549	0.00	17.41	26.02
26.03	RHC IV URGENT CARE	579	515	8,814	0.00	8.94	26.03
26.04	RHC V SPC IM Peds	4,196	1,569	22,958	0.00	28.38	26.04
26.05	RHC VI JENNINGS	0	10	1,223	0.00	1.52	26.05
26.06	RHC VII SCOTT	0	2	782	0.00	0.60	26.06
26.07	RHC VIII WASHINGTON CO	0	0	637	0.00	1.62	26.07
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	887.14	27.00
28.00	Observation Bed Days		369	1,987			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	122	205			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: 15-0065

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2024 10:24 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	347	499	2,082	1.00
2.00	HMO and other (see instructions)			116	91		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	347	499	2,082	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	RHC I JACKSON	0.00					26.00
26.01	RHC II BROWSTOWN	0.00					26.01
26.02	RHC III OBGYN	0.00					26.02
26.03	RHC IV URGENT CARE	0.00					26.03
26.04	RHC V SPC IM PEDS	0.00					26.04
26.05	RHC VI JENNINGS	0.00					26.05
26.06	RHC VII SCOTT	0.00					26.06
26.07	RHC VIII WASHINGTON CO	0.00					26.07
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days				0		33.00
33.01	LTCH site neutral days and discharges				0		33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2024 10:24 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	86,447,193	0	86,447,193	1,845,244.00	46.85
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthesiologist Part B		648,167	0	648,167	6,147.00	105.44
4.00	Physician-Part A - Administrative		1,458,845	0	1,458,845	8,163.00	178.71
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		12,615,354	0	12,615,354	56,635.00	222.75
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,104,830	0	1,104,830	16,999.00	64.99
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		12,725,714	-631,254	12,094,460	252,228.00	47.95
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		4,858,588	0	4,858,588	63,954.00	75.97
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		348,333	0	348,333	2,386.00	145.99
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		17,876,300	0	17,876,300		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		3,170,144	0	3,170,144		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		120,763	0	120,763		
22.00	Physician Part A - Administrative		182,191	0	182,191		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,354,970	0	1,354,970		
24.00	Wage-related costs (RHC/FQHC)		289,253	0	289,253		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2024 10:24 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	779,991	0	779,991	15,040.00	51.86	26.00
27.00	Administrative & General	10,997,789	557,792	11,555,581	232,117.00	49.78	27.00
28.00	Administrative & General under contract (see inst.)	829,094	0	829,094	2,666.00	310.99	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,478,977	0	1,478,977	42,942.00	34.44	30.00
31.00	Laundry & Linen Service	50,355	0	50,355	2,827.00	17.81	31.00
32.00	Housekeeping	1,046,407	0	1,046,407	57,098.00	18.33	32.00
33.00	Housekeeping under contract (see instructions)	237,820	0	237,820	12,404.00	19.17	33.00
34.00	Dietary	663,140	-446,565	216,575	10,428.00	20.77	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	446,565	446,565	22,195.00	20.12	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,973,181	-409	2,972,772	65,253.00	45.56	38.00
39.00	Central Services and Supply	926,632	0	926,632	37,215.00	24.90	39.00
40.00	Pharmacy	1,726,145	0	1,726,145	35,451.00	48.69	40.00
41.00	Medical Records & Medical Records Library	1,050,707	0	1,050,707	41,473.00	25.33	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	1,110,178	0	1,110,178	27,557.00	40.29	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2024 10:24 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	73,145,756	0	73,145,756	1,780,533.00	41.08	1.00
2.00	Excluded area salaries (see instructions)	12,725,714	-631,254	12,094,460	252,228.00	47.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)	60,420,042	631,254	61,051,296	1,528,305.00	39.95	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,206,921	0	5,206,921	66,340.00	78.49	4.00
5.00	Subtotal wage-related costs (see inst.)	18,058,491	0	18,058,491	0.00	29.58	5.00
6.00	Total (sum of lines 3 thru 5)	83,685,454	631,254	84,316,708	1,594,645.00	52.87	6.00
7.00	Total overhead cost (see instructions)	23,870,416	557,383	24,427,799	604,666.00	40.40	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 10:24 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,899,675	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	102,435	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	14,469,099	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,947	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	570,655	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	9,461	14.00
15.00	'Workers' Compensation Insurance	267,514	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	5,444,044	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	187,791	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,993,621	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/29/2024 10:24 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,858,588	22,993,621	1.00
2.00	Hospital	4,858,588	22,993,621	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	0	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	0	14.07
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-7155		Period: From 01/01/2023 To 12/31/2023		Worksheet S-4 Date/Time Prepared: 5/29/2024 10:24 am	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	877	0	1,141	2,018	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	243.00	0.00	546.00	789.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.06	0.00	1.06	4.00
5.00	Other Administrative Personnel			1.05	0.00	1.05	5.00
6.00	Direct Nursing Service			7.09	0.00	7.09	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			4.52	0.00	4.52	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.59	0.00	2.59	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.13	0.00	0.13	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.97	0.00	0.97	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					18020	20.00
20.01						31140	20.01
20.02						99915	20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,070	90	35	16	1,211	21.00
22.00	Skilled Nursing Visit Charges	304,950	25,650	9,975	4,560	345,135	22.00
23.00	Physical Therapy Visits	962	21	20	4	1,007	23.00
24.00	Physical Therapy Visit Charges	320,346	6,993	6,660	1,332	335,331	24.00
25.00	Occupational Therapy Visits	480	23	8	1	512	25.00
26.00	Occupational Therapy Visit Charges	159,840	7,703	2,664	333	170,540	26.00
27.00	Speech Pathology Visits	28	3	0	0	31	27.00
28.00	Speech Pathology Visit Charges	9,324	999	0	0	10,323	28.00
29.00	Medical Social Service Visits	4	0	0	0	4	29.00
30.00	Medical Social Service Visit Charges	1,640	0	0	0	1,640	30.00
31.00	Home Health Aide Visits	207	15	1	0	223	31.00
32.00	Home Health Aide Visit Charges	32,499	2,355	157	0	35,011	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,751	152	64	21	2,988	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	828,599	43,700	19,456	6,225	897,980	35.00
36.00	Total Number of Episodes (standard/non outlier)	409		38	4	451	36.00
37.00	Total Number of Outlier Episodes		10		0	10	37.00
38.00	Total Non-Routine Medical Supply Charges	14,036	620	433	159	15,248	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8564		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	1124 MEDICAL PLACE				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	SEYMOUR		IN		47274	
				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			
4.00		Source of Federal Funds				4.00	
5.00		Community Health Center (Section 330(d), PHS Act)				5.00	
6.00		Migrant Health Center (Section 329(d), PHS Act)				6.00	
7.00		Health Services for the Homeless (Section 340(d), PHS Act)				7.00	
8.00		Appalachian Regional Commission				8.00	
9.00		Look-Alikes				8.00	
		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	
11.00	Facility hours of operations (1) CLINIC	07:30		17:00		07:30	
						1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				0 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N				0 13.00	
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N				0 13.01	
		Provider name		CCN			
		1.00		2.00			
14.00	RHC/FQHC name, CCN	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)						

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8564

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

		RHC I		Cost	
		County			
		4.00			
2.00	City, State, ZIP Code, County	JACKSON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
		Facility hours of operations (1)			
11.00	CLINIC	17:00	07:30	17:00	07:30
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
		Facility hours of operations (1)			
11.00	CLINIC	07:30	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8565	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
			RHC II	Cost	
			1.00		
1.00	Clinic Address and Identification Street		806 W. COMMERCE STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		BROWNSTOWN IN 47220		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	
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)				4.00
6.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
8.00	Appalachian Regional Commission				7.00
9.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		
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	
11.00	Facility hours of operations (1) 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?				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N 0 13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N 0 13.01
			Provider name	CCN	
			1.00	2.00	
14.00	RHC/FQHC name, CCN				14.00
		Y/N	V	XVII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	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, XVII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8565

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

		RHC II		Cost	
		County			
		4.00			
2.00	City, State, ZIP Code, County	JACKSON		2.00	
		Tuesday		Wednesday	
		to		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
		Thursday		Friday	
		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: 15-0065 Component CCN: 15-8566		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
		RHC III		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		411 W. TIPTON STREET		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		SEYMOUR IN 47274		2.00	
				1.00			
3.00	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	
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	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	
				Sunday		Monday	
				Tuesday			
				from		to	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1) CLINIC		08:00 17:00		08:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		0	
13.00	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	
13.01	13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.		N		0	
				Provider name		CCN	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN					
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				5.00		Total Visits	
15.00	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)					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8566

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am
RHC III
Cost

		County				
		4.00				
2.00	City, State, ZIP Code, County	JACKSON				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
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8568		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
				RHC IV		Cost	
				1.00			
1.00	Clinic Address and Identification Street			1130 MEDICAL PALACE		1.00	
				City		State	
				1.00		2.00	
2.00	City, State, ZIP Code, County			SEYMOUR IN		47274	
				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	
4.00	Source of Federal Funds 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	
				from to		from to	
				1.00 2.00		3.00 4.00	
				Tuesday		from	
						5.00	
11.00	Facility hours of operations (1) CLINIC			08:00 17:00		08:00 20:00	
				08:00		11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		0 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N		0 13.01	
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00	
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8568

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

		RHC IV			Cost		
		County					
		4.00					
2.00	City, State, ZIP Code, County	JACKSON			2.00		
		Tuesday		Wednesday		Thursday	
		to		to		to	
		6.00		7.00		8.00	
		9.00		10.00			
Facility hours of operations (1)							
11.00	CLINIC	20:00	08:00	20:00	08:00	20:00	11.00
		Friday		Saturday			
		from		from		to	
		11.00		12.00		13.00	
		14.00					
Facility hours of operations (1)							
11.00	CLINIC	08:00	20:00	08:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8569		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
		RHC V		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		411 W TIPTON		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		SEYMOUR IN 47274		2.00	
				1.00			
3.00	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	
4.00	4.00	Source of Federal Funds				4.00	
5.00	5.00	Community Health Center (Section 330(d), PHS Act)				5.00	
6.00	6.00	Migrant Health Center (Section 329(d), PHS Act)				6.00	
7.00	7.00	Health Services for the Homeless (Section 340(d), PHS Act)				7.00	
8.00	8.00	Appalachian Regional Commission				8.00	
9.00	9.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	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	
				Sunday		Monday	
				Tuesday			
				from		to	
				1.00		2.00	
				from		to	
				3.00		4.00	
				from		to	
				5.00			
11.00	11.00	Facility hours of operations (1)		CLINIC		07:30 17:00 07:30	
						1.00 2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		0	
13.00	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	
13.01	13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.		N		0	
				Provider name		CCN	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN					
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	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)					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8569

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

		RHC V		Cost	
		County			
		4.00			
2.00	City, State, ZIP Code, County	JACKSON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
		Facility hours of operations (1)			
11.00	CLINIC	17:00	07:30	17:00	07:30
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
		Facility hours of operations (1)			
11.00	CLINIC	07:30	17:00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8575		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
				RHC VI		Cost	
				1.00			
1.00	Clinic Address and Identification Street			2145 N STATE HWY 3		1.00	
				City State ZIP Code			
				1.00 2.00 3.00			
2.00	City, State, ZIP Code, County			NORTH VERNON IN 47265		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	
4.00	Source of Federal Funds 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	
				from to		from to	
				1.00 2.00		3.00 4.00	
				Tuesday		from	
						5.00	
11.00	Facility hours of operations (1) 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		0 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N		0 13.01	
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00	
				Y/N V		XVIII XIX Total Visits	
				1.00 2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8575

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

		RHC VI		Cost	
		County			
		4.00			
2.00	City, State, ZIP Code, County	JENNINGS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		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
		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: 15-0065 Component CCN: 15-8574		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
				RHC VII		Cost	
				1.00			
1.00	Clinic Address and Identification Street			1366 N. GARDNER ST.		1.00	
				City		State	
				1.00		2.00	
2.00	City, State, ZIP Code, County			SCOTTSBURG IN		47170 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	
4.00	Source of Federal Funds 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	
				from to		from to	
				1.00 2.00		3.00 4.00	
				Tuesday		from	
						5.00	
11.00	Facility hours of operations (1) 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		0 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N		0 13.01	
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00	
				Y/N		V	
				1.00		2.00	
				XVII		XIX	
				3.00		4.00	
				Total Visits		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, XVII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8574		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
				RHC VII		Cost	
		County					
		4.00					
2.00	City, State, ZIP Code, County	SCOTT				2.00	
		Tuesday		Wednesday		Thursday	
		to		to		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
		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: 15-0065 Component CCN: 15-8578		Period: From 01/01/2023 To 12/31/2023		Worksheet S-8 Date/Time Prepared: 5/29/2024 10:24 am	
				RHC VIII		Cost	
				1.00			
1.00	Clinic Address and Identification Street			403 S. MAIN ST.		1.00	
				City		State	
				1.00		2.00	
2.00	City, State, ZIP Code, County			SALEM IN		47167 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	
4.00	Source of Federal Funds 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	
				from to		from to	
				1.00 2.00		3.00 4.00	
				Tuesday		from	
						5.00	
11.00	Facility hours of operations (1) 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		0 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N		0 13.01	
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00	
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065
Component CCN: 15-8578

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

Worksheet S-8
Date/Time Prepared:
5/29/2024 10:24 am

RHC VIII Cost

		County					
		4.00					
2.00	City, State, ZIP Code, County	WASHINGTON				2.00	
		Tuesday		Wednesday		Thursday	
		to		to		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
		Friday		Saturday			
		from		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 HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0065 Hospice CCN: 15-1529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/29/2024 10:24 am
		Hospice I		

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	11,086	295	91	11,472	11.00
12.00	Hospice Inpatient Respite Care	37	18	0	55	12.00
13.00	Hospice General Inpatient Care	125	0	0	125	13.00
14.00	Total Hospice Days	11,248	313	91	11,652	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 10:24 am
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				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)			0.310517	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			31,112,465	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?			Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			108,072,465	6.00	
7.00	Medicaid cost (line 1 times line 6)			33,558,338	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			2,445,873	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,445,873	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)						
20.00	Charity care charges and uninsured discounts (see instructions)		2,732,971	432,428	3,165,399	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)		848,634	273,996	1,122,630	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)		848,634	273,996	1,122,630	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)			229,784	25.01	
26.00	Bad debt amount (see instructions)			5,318,957	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			181,489	27.00	
27.01	Medicare allowable bad debts (see instructions)			279,213	27.01	
28.00	Non-Medicare bad debt amount (see instructions)			5,039,744	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,662,650	29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			2,785,280	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,231,153	31.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 10:24 am
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				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.279477	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)	2,487,357	369,911	2,857,268	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	695,159	225,835	920,994	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)	695,159	225,835	920,994	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)			199,960	25.01
26.00	Bad debt amount (see instructions)			5,316,415	26.00
27.00	Medicare reimbursable bad debts (see instructions)			177,759	27.00
27.01	Medicare allowable bad debts (see instructions)			273,475	27.01
28.00	Non-Medicare bad debt amount (see instructions)			5,042,940	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,505,102	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			2,426,096	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,426,096	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		13,451,777	-4,165,051	9,286,726	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	5,319,844	5,319,844	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	779,991	22,971,920	0	23,751,911	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,997,789	16,134,647	240,977	27,373,413	5.00
7.00	00700	OPERATION OF PLANT	1,478,977	3,125,069	0	4,604,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,355	401,100	0	451,455	8.00
9.00	00900	HOUSEKEEPING	1,046,407	583,393	1,629,800	1,629,800	9.00
10.00	01000	DIETARY	663,140	533,626	-805,917	390,849	10.00
11.00	01100	CAFETERIA	0	0	805,917	805,917	11.00
13.00	01300	NURSING ADMINISTRATION	2,973,181	2,324,688	-25,228	5,272,641	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	926,632	6,505,361	-5,927,959	1,504,034	14.00
15.00	01500	PHARMACY	1,726,145	16,381,032	-12,871,864	5,235,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,050,707	221,328	0	1,272,035	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	1,110,178	226,305	1,336,483	1,336,483	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	648,167	648,167	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,553,697	2,538,677	-2,975,889	7,116,485	30.00
31.00	03100	INTENSIVE CARE UNIT	1,776,790	2,215,838	0	3,992,628	31.00
43.00	04300	NURSERY	0	0	1,713,361	1,713,361	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,490,613	6,386,562	-22,597	10,854,578	50.00
51.00	05100	RECOVERY ROOM	658,547	91,204	0	749,751	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,144,865	1,144,865	52.00
53.00	05300	ANESTHESIOLOGY	4,513,460	43,155	-672,167	3,884,448	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,604,190	1,269,656	-95,559	2,778,287	54.00
54.01	03630	ULTRA SOUND	551,944	160,186	22,299	734,429	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	147,971	-74,015	73,956	54.02
57.00	05700	CT SCAN	400,742	861,214	-77,749	1,184,207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	193,826	231,632	-24,215	401,243	58.00
60.00	06000	LABORATORY	1,657,987	4,228,360	0	5,886,347	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	289,397	0	289,397	63.00
64.00	06400	INTRAVENOUS THERAPY	322,052	120,889	-173	442,768	64.00
65.00	06500	RESPIRATORY THERAPY	1,137,458	957,106	-256,662	1,837,902	65.00
66.00	06600	PHYSICAL THERAPY	1,491,149	16,173	-11	1,507,311	66.00
67.00	06700	OCCUPATIONAL THERAPY	451,044	46,267	0	497,311	67.00
68.00	06800	SPEECH PATHOLOGY	321,455	3,395	0	324,850	68.00
69.00	06900	ELECTROCARDIOLOGY	159,552	113,481	-73,152	199,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	875,811	875,811	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	5,244,930	5,244,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,411,068	13,411,068	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	441,227	61,037	-2,021	500,243	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1,406,450	161,907	-45,607	1,522,750	76.03
76.04	03610	SLEEP LAB	243,409	124,991	60,626	429,026	76.04
76.05	03480	ONCOLOGY	2,634,562	913,870	-157	3,548,275	76.05
76.97	07697	CARDIAC REHABILITATION	187,369	33,161	0	220,530	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	1,397,666	168,373	0	1,566,039	88.00
88.01	08801	RHC II BROWSTOWN	462,477	103,304	0	565,781	88.01
88.02	08802	RHC III OBGYN	2,871,596	219,425	-15,000	3,076,021	88.02
88.03	08803	RHC IV URGENT CARE	609,707	144,139	0	753,846	88.03
88.04	08804	RHC V SPC IM PEDS	2,811,488	398,573	-20,000	3,190,061	88.04
88.05	08805	RHC VI JENNINGS	0	0	186,855	186,855	88.05
88.06	08806	RHC VII SCOTT	0	0	68,733	68,733	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	215,728	215,728	88.07
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02	09002	VEIN CENTER	430,890	154,842	0	585,732	90.02
90.03	09003	OBGYN	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	954,615	277	-85	954,807	90.04
90.05	09005	SURGICAL ASSOCIATES	2,942,508	16,286	-426	2,958,368	90.05
91.00	09100	EMERGENCY	5,562,524	1,470,171	0	7,032,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	676,983	1,572	-20,076	658,479	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,776,585	121,403	-158,529	1,739,459	101.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

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

Worksheet A
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE		837,978	837,978	-837,978	0	113.00
116.00	11600 HOSPICE	655,965	175,809	831,774	118,938	950,712	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	76,154,029	107,688,527	183,842,556	910,032	184,752,588	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4,756,486	1,428,484	6,184,970	-309,588	5,875,382	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	0	898,141	898,141	0	898,141	194.01
194.02	07952 EXTERNAL SVCS MARKETING	253,508	589,511	843,019	0	843,019	194.02
194.03	07953 WASHINGTON CLINIC	226,774	552,837	779,611	-215,728	563,883	194.03
194.04	07954 PHYSICIAN OFFICES	1,479,593	249,192	1,728,785	0	1,728,785	194.04
194.05	07955 INTEGRATED MEDICINE	577,692	230,193	807,885	-355,485	452,400	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	728,623	76,254	804,877	0	804,877	194.08
194.09	07959 UROLOGY PROF	1,604,845	1,351,889	2,956,734	-9,231	2,947,503	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	665,643	66,951	732,594	-20,000	712,594	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	86,447,193	113,131,979	199,579,172	0	199,579,172	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

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

Worksheet A
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-488,183	8,798,543	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	5,319,844	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,906,200	20,845,711	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-9,468,986	17,904,427	5.00
7.00	00700 OPERATION OF PLANT	0	4,604,046	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	451,455	8.00
9.00	00900 HOUSEKEEPING	0	1,629,800	9.00
10.00	01000 DIETARY	-27,035	363,814	10.00
11.00	01100 CAFETERIA	-503,012	302,905	11.00
13.00	01300 NURSING ADMINISTRATION	0	5,272,641	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,504,034	14.00
15.00	01500 PHARMACY	-1,235,383	3,999,930	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-15,372	1,256,663	16.00
18.00	01850 PHYSICIAN PRIVATE PRACTICE	0	1,336,483	18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	-648,167	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-1,658,494	5,457,991	30.00
31.00	03100 INTENSIVE CARE UNIT	-15,666	3,976,962	31.00
43.00	04300 NURSERY	0	1,713,361	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-31,015	10,823,563	50.00
51.00	05100 RECOVERY ROOM	0	749,751	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,144,865	52.00
53.00	05300 ANESTHESIOLOGY	-3,841,293	43,155	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-37,500	2,740,787	54.00
54.01	03630 ULTRA SOUND	-8,620	725,809	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	73,956	54.02
57.00	05700 CT SCAN	-26,300	1,157,907	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	401,243	58.00
60.00	06000 LABORATORY	-59,723	5,826,624	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	289,397	63.00
64.00	06400 INTRAVENOUS THERAPY	0	442,768	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,837,902	65.00
66.00	06600 PHYSICAL THERAPY	0	1,507,311	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	497,311	67.00
68.00	06800 SPEECH PATHOLOGY	0	324,850	68.00
69.00	06900 ELECTROCARDIOLOGY	0	199,881	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	875,811	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,244,930	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-328,084	13,082,984	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	0	500,243	76.00
76.01	03953 OTHER ANCILLARY CMS LINE	0	0	76.01
76.02	03951 CASE MANAGEMENT	0	0	76.02
76.03	03950 PAIN MANAGEMENT	-966,260	556,490	76.03
76.04	03610 SLEEP LAB	0	429,026	76.04
76.05	03480 ONCOLOGY	-1,431,016	2,117,259	76.05
76.97	07697 CARDIAC REHABILITATION	0	220,530	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC I JACKSON	0	1,566,039	88.00
88.01	08801 RHC II BROWSTOWN	0	565,781	88.01
88.02	08802 RHC III OBGYN	0	3,076,021	88.02
88.03	08803 RHC IV URGENT CARE	0	753,846	88.03
88.04	08804 RHC V SPC IM PEDS	0	3,190,061	88.04
88.05	08805 RHC VI JENNINGS	0	186,855	88.05
88.06	08806 RHC VII SCOTT	0	68,733	88.06
88.07	08807 RHC VIII WASHINGTON CO	0	215,728	88.07
90.00	09000 CLINIC	0	0	90.00
90.01	09001 PALLIATIVE HEALTH	0	0	90.01
90.02	09002 VEIN CENTER	-305,675	280,057	90.02
90.03	09003 OBGYN	0	0	90.03
90.04	09004 NEUROSURGERY	-836,311	118,496	90.04
90.05	09005 SURGICAL ASSOCIATES	-2,631,114	327,254	90.05
91.00	09100 EMERGENCY	-2,618,373	4,414,322	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04952 BEHAVIORAL HEALTH	-334,097	324,382	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	1,739,459	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	102.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

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

Worksheet A
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	950,712	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-30,421,879	154,330,709	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,875,382	192.00
194.00	07950	WELLNESS	0	0	194.00
194.01	07951	JACKSON MOB	0	898,141	194.01
194.02	07952	EXTERNAL SVCS MARKETING	0	843,019	194.02
194.03	07953	WASHINGTON CLINIC	0	563,883	194.03
194.04	07954	PHYSICIAN OFFICES	0	1,728,785	194.04
194.05	07955	INTEGRATED MEDICINE	0	452,400	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	194.07
194.08	07958	EMPLOYER CLINIC	0	804,877	194.08
194.09	07959	UROLOGY PROF	0	2,947,503	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	194.11
194.12	07962	SPC	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	0	712,594	194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	-30,421,879	169,157,293	200.00

RECLASSIFICATIONS

Provider CCN: 15-0065

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

Worksheet A-6

Date/Time Prepared:
5/29/2024 10:24 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,240,097	1.00
	O		0	5,240,097	
B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	237,068	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	79,747	2.00
	O		0	316,815	
C - CAFETERIA					
1.00	CAFETERIA	11.00	446,565	359,352	1.00
	O		446,565	359,352	
D - BOND INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	837,978	1.00
	O		0	837,978	
E - NURSERY					
1.00	NURSERY	43.00	1,592,298	121,063	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,063,971	80,894	2.00
	O		2,656,269	201,957	
F - NONPHYSICIAN ANESTHETIST					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	648,167	0	1.00
	O		648,167	0	
G - HOME HEALTH SOCIAL WORKER					
1.00	HOME HEALTH AGENCY	101.00	409	0	1.00
	O		409	0	
H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,411,068	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	O		0	13,411,068	
I - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,120,741	1.00
2.00		0.00	0	0	2.00
	O		0	6,120,741	
J - IMPLANTABLE DEVICE					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	5,244,930	1.00
	O		0	5,244,930	
K - RESPIRATORY THERAPY DIRECTOR					
1.00	SLEEP LAB	76.04	60,626	0	1.00
	O		60,626	0	
L - RADIOLOGY DIRECTOR					
1.00	ULTRA SOUND	54.01	23,227	0	1.00
2.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	15,485	0	2.00
3.00	CT SCAN	57.00	23,227	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	23,227	0	4.00
	O		85,166	0	
M - HOSPICE RECLASS					
1.00	HOSPICE	116.00	158,938	0	1.00
	O		158,938	0	
N - SCOTT PHYSICIAN RECLASS					
1.00	RHC VII SCOTT	88.06	23,517	45,216	1.00
	O		23,517	45,216	
O - MEDICAL DIRECTOR RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	557,792	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
			557,792	0	
P - JENNINGS PHYSICIAN RECLASS					
1.00	RHC VI JENNINGS	88.05	66,679	120,176	1.00
			66,679	120,176	
Q - WASHINGTON PHYSICIAN RECLASS					
1.00	RHC VII WASHINGTON CO	88.07	62,751	152,977	1.00
	TOTALS		62,751	152,977	
500.00	Grand Total: Increases		4,766,879	32,051,307	500.00

RECLASSIFICATIONS

Provider CCN: 15-0065

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

Worksheet A-6
Date/Time Prepared:
5/29/2024 10:24 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,240,097	9		1.00
	O		0	5,240,097			
B - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	316,815	12		1.00
2.00	O	0.00	0	0	12		2.00
	O		0	316,815			
C - CAFETERIA							
1.00	DIETARY	10.00	446,565	359,352	0		1.00
	O		446,565	359,352			
D - BOND INTEREST							
1.00	INTEREST EXPENSE	113.00	0	837,978	11		1.00
	O		0	837,978			
E - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	2,656,269	201,957	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		2,656,269	201,957			
F - NONPHYSICIAN ANESTHETIST							
1.00	ANESTHESIOLOGY	53.00	648,167	0	0		1.00
	O		648,167	0			
G - HOME HEALTH SOCIAL WORKER							
1.00	NURSING ADMINISTRATION	13.00	409	0	0		1.00
	O		409	0			
H - DRUGS							
1.00	NURSING ADMINISTRATION	13.00	0	24,819	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	864	0		2.00
3.00	PHARMACY	15.00	0	12,871,864	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	117,663	0		4.00
5.00	OPERATING ROOM	50.00	0	22,597	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,393	0		6.00
7.00	ULTRA SOUND	54.01	0	928	0		7.00
8.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	89,500	0		8.00
9.00	CT SCAN	57.00	0	100,976	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	47,442	0		10.00
11.00	INTRAVENOUS THERAPY	64.00	0	173	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	2,390	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	11	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	73,152	0		14.00
15.00	WOUND CARE (DIABETES CENTER)	76.00	0	2,021	0		15.00
16.00	PAIN MANAGEMENT	76.03	0	45,607	0		16.00
17.00	ONCOLOGY	76.05	0	157	0		17.00
18.00	NEUROSURGERY	90.04	0	85	0		18.00
19.00	SURGICAL ASSOCIATES	90.05	0	426	0		19.00
	O		0	13,411,068			
I - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,927,095	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	193,646	0		2.00
	O		0	6,120,741			
J - IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,244,930	0		1.00
	O		0	5,244,930			
K - RESPIRATORY THERAPY DIRECTOR							
1.00	RESPIRATORY THERAPY	65.00	60,626	0	0		1.00
	O		60,626	0			
L - RADIOLOGY DIRECTOR							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	85,166	0	0		1.00
2.00	O	0.00	0	0	0		2.00
3.00	O	0.00	0	0	0		3.00
4.00	O	0.00	0	0	0		4.00
	O		85,166	0			
M - HOSPICE RECLASS							
1.00	HOME HEALTH AGENCY	101.00	158,938	0	0		1.00
	O		158,938	0			
N - SCOTT PHYSICIAN RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	23,517	45,216	0		1.00
	O		23,517	45,216			
O - MEDICAL DIRECTOR RECLASS							
1.00	INTEGRATED MEDICINE	194.05	355,485	0	0		1.00
2.00	BEHAVIORAL HEALTH	93.00	20,076	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	54,000	0	0		3.00
4.00	PULMONARY PROFESSIONAL	194.13	20,000	0	0		4.00

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Provider CCN: 15-0065

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

Worksheet A-6
Date/Time Prepared:
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00			
5.00	UROLOGY PROF	194.09	9,231	0	0	0		5.00
6.00	ANESTHESIOLOGY	53.00	24,000	0	0	0		6.00
7.00	HOSPICE	116.00	40,000	0	0	0		7.00
8.00	RHC V SPC IM PEDS	88.04	20,000	0	0	0		8.00
9.00	RHC III OBGYN	88.02	15,000	0	0	0		9.00
			557,792	0				
P - JENNINGS PHYSICIAN RECLASS								
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	66,679	120,176	0	0		1.00
			66,679	120,176				
Q - WASHINGTON PHYSICIAN RECLASS								
1.00	WASHINGTON CLINIC	194.03	62,751	152,977	0	0		1.00
	TOTALS		62,751	152,977				
500.00	Grand Total: Decreases		4,766,879	32,051,307				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2024 10:24 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,751,025	0	0	0	1.00	
2.00	Land Improvements	4,929,504	78,556	0	78,556	2.00	
3.00	Buildings and Fixtures	152,897,869	3,090,027	0	3,090,027	3.00	
4.00	Building Improvements	6,150,745	562,276	0	562,276	4.00	
5.00	Fixed Equipment	8,726,103	726,713	0	726,713	5.00	
6.00	Movable Equipment	63,525,086	1,559,948	0	1,559,948	6.00	
7.00	HIT designated Assets	4,539,989	7,203,470	0	7,203,470	7.00	
8.00	Subtotal (sum of lines 1-7)	252,520,321	13,220,990	0	13,220,990	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	252,520,321	13,220,990	0	13,220,990	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,751,025	0			1.00	
2.00	Land Improvements	5,008,060	0			2.00	
3.00	Buildings and Fixtures	155,987,896	0			3.00	
4.00	Building Improvements	6,713,021	0			4.00	
5.00	Fixed Equipment	9,452,816	0			5.00	
6.00	Movable Equipment	65,085,034	0			6.00	
7.00	HIT designated Assets	11,743,459	0			7.00	
8.00	Subtotal (sum of lines 1-7)	265,741,311	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	265,741,311	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	13,451,777	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,451,777	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	13,451,777				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	13,451,777				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	200,656,277	0	200,656,277	0.755081	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,085,034	0	65,085,034	0.244919	0	2.00
3.00	Total (sum of lines 1-2)	265,741,311	0	265,741,311	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,211,680	-90,893	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,240,097	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,451,777	-90,893	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	440,688	237,068	0	0	8,798,543	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	79,747	0	0	5,319,844	2.00
3.00	Total (sum of lines 1-2)	440,688	316,815	0	0	14,118,387	3.00

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-397,290	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-72,041	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-90,893	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-965	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-13,790,945			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-503,012	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-328,084	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-15,372	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-648,167	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0065

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

Worksheet A-8

Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
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 HOSPITAL ASSESSMENT FEE	A	-8,871,978		ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 ADMIN AND GENERAL MARKETING	A	-4,035		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 ADULTS AND PEDS MARKETING	A	-654		ADULTS & PEDIATRICS	30.00	0	33.02
33.03 SURGICAL PROF MARKETING	A	-1,708		SURGICAL ASSOCIATES	90.05	0	33.03
33.04 ICCU MARKETING	A	-75		INTENSIVE CARE UNIT	31.00	0	33.04
33.05 ENDOSCOPY MARKETING	A	-106		OPERATING ROOM	50.00	0	33.05
33.06 PHYSICIAN RECRUITMENT	A	-200,004		ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 MISC INCOME - DIETARY	B	-27,035		DIETARY	10.00	0	33.07
33.08 340B RETAIL PHARMACY EXP	A	-907,697		PHARMACY	15.00	0	33.08
33.09 MISC INCOME - ADMIN & GENERAL	B	163,360		ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 MISC INCOME - OPERATING ROOM	B	30,616		OPERATING ROOM	50.00	0	33.10
33.11 LOBBYING DUES	A	-12,550		ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 TELEPHONE OPERATOR BENEFITS	A	-41		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 CRNA OFFSET - BENEFITS	A	-127,494		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14 APRN OFFSET	A	-252,190		ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 APRN OFFSET	A	-458,920		ADULTS & PEDIATRICS	30.00	0	33.15
33.16 APRN OFFSET	A	-226,297		PAIN MANAGEMENT	76.03	0	33.16
33.17 APRN OFFSET	A	-98,738		NEUROSURGERY	90.04	0	33.17
33.18 APRN OFFSET	A	-161,853		SURGICAL ASSOCIATES	90.05	0	33.18
33.19 APRN OFFSET	A	-102,397		EMERGENCY	91.00	0	33.19
33.20 APRN OFFSET - BENEFITS	A	-255,787		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21 PA - OFFSET	A	-12,950		PAIN MANAGEMENT	76.03	0	33.21
33.22 PA - OFFSET	A	-85,787		NEUROSURGERY	90.04	0	33.22
33.23 PA - OFFSET	A	-110,506		EMERGENCY	91.00	0	33.23
33.24 PA BENEFITS OFFSET	A	-41,158		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25 EMPLOYEE PHARMACY OFFSET	B	-327,686		PHARMACY	15.00	0	33.25
33.26 PHYSICIAN BENEFITS OFFSET	A	-2,481,440		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-30,421,879					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: 15-0065

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2024 10:24 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00 EMPLOYEE BENEFITS DEPARTMENT	280	280	0	211,500	0	1.00
2.00	5.00 ADMINISTRATIVE & GENERAL	650,734	2,938	647,796	211,500	4,250	2.00
3.00	30.00 ADULTS & PEDIATRICS	1,228,205	1,126,505	101,700	211,500	288	3.00
4.00	31.00 INTENSIVE CARE UNIT	48,333	0	48,333	211,500	322	4.00
5.00	50.00 OPERATING ROOM	61,525	61,525	0	246,400	0	5.00
6.00	53.00 ANESTHESIOLOGY	3,841,293	3,841,293	0	239,400	0	6.00
7.00	54.00 RADIOLOGY-DIAGNOSTIC	37,500	37,500	0	271,900	0	7.00
8.00	54.01 ULTRA SOUND	8,620	8,620	0	271,900	0	8.00
9.00	57.00 CT SCAN	26,300	26,300	0	271,900	0	9.00
10.00	60.00 LABORATORY	300,000	0	300,000	260,300	1,920	10.00
11.00	76.03 PAIN MANAGEMENT	731,340	727,013	4,327	211,500	138	11.00
12.00	76.04 SLEEP LAB	24,039	0	24,039	211,500	520	12.00
13.00	76.05 ONCOLOGY	1,670,275	1,039,291	630,984	211,500	2,353	13.00
14.00	90.02 VEIN CENTER	315,843	300,843	15,000	211,500	100	14.00
15.00	90.04 NEUROSURGERY	651,786	651,786	0	211,500	0	15.00
16.00	90.05 SURGICAL ASSOCIATES	2,481,585	2,466,585	15,000	211,500	138	16.00
17.00	91.00 EMERGENCY	2,425,470	2,405,470	20,000	211,500	520	17.00
18.00	93.00 BEHAVIORAL HEALTH	334,097	334,097	0	181,300	0	18.00
200.00		14,837,225	13,030,046	1,807,179		10,549	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	4.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00 ADMINISTRATIVE & GENERAL	432,151	21,608	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	29,285	1,464	0	0	0	3.00
4.00	31.00 INTENSIVE CARE UNIT	32,742	1,637	0	0	0	4.00
5.00	50.00 OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00 ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	54.01 ULTRA SOUND	0	0	0	0	0	8.00
9.00	57.00 CT SCAN	0	0	0	0	0	9.00
10.00	60.00 LABORATORY	240,277	12,014	0	0	0	10.00
11.00	76.03 PAIN MANAGEMENT	14,032	702	0	0	0	11.00
12.00	76.04 SLEEP LAB	52,875	2,644	0	0	0	12.00
13.00	76.05 ONCOLOGY	239,259	11,963	0	0	0	13.00
14.00	90.02 VEIN CENTER	10,168	508	0	0	0	14.00
15.00	90.04 NEUROSURGERY	0	0	0	0	0	15.00
16.00	90.05 SURGICAL ASSOCIATES	14,032	702	0	0	0	16.00
17.00	91.00 EMERGENCY	52,875	2,644	0	0	0	17.00
18.00	93.00 BEHAVIORAL HEALTH	0	0	0	0	0	18.00
200.00		1,117,696	55,886	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	4.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	280	1.00
2.00	5.00 ADMINISTRATIVE & GENERAL	0	432,151	215,645	218,583	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	29,285	72,415	1,198,920	3.00
4.00	31.00 INTENSIVE CARE UNIT	0	32,742	15,591	15,591	4.00
5.00	50.00 OPERATING ROOM	0	0	0	61,525	5.00
6.00	53.00 ANESTHESIOLOGY	0	0	0	3,841,293	6.00
7.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	37,500	7.00
8.00	54.01 ULTRA SOUND	0	0	0	8,620	8.00
9.00	57.00 CT SCAN	0	0	0	26,300	9.00
10.00	60.00 LABORATORY	0	240,277	59,723	59,723	10.00
11.00	76.03 PAIN MANAGEMENT	0	14,032	0	727,013	11.00
12.00	76.04 SLEEP LAB	0	52,875	0	0	12.00
13.00	76.05 ONCOLOGY	0	239,259	391,725	1,431,016	13.00
14.00	90.02 VEIN CENTER	0	10,168	4,832	305,675	14.00
15.00	90.04 NEUROSURGERY	0	0	0	651,786	15.00
16.00	90.05 SURGICAL ASSOCIATES	0	14,032	968	2,467,553	16.00
17.00	91.00 EMERGENCY	0	52,875	0	2,405,470	17.00
18.00	93.00 BEHAVIORAL HEALTH	0	0	0	334,097	18.00
200.00		0	1,117,696	760,899	13,790,945	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	8,798,543	8,798,543			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,319,844		5,319,844		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	20,845,711	89,849	0	20,935,560	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,904,427	753,640	1,068,445	3,957,587	5.00
7.00 00700	OPERATION OF PLANT	4,604,046	473,995	545,338	518,006	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	451,455	28,938	0	17,637	8.00
9.00 00900	HOUSEKEEPING	1,629,800	44,418	14,719	366,500	9.00
10.00 01000	DIETARY	363,814	54,218	27,084	75,852	10.00
11.00 01100	CAFETERIA	302,905	111,817	0	156,408	11.00
13.00 01300	NURSING ADMINISTRATION	5,272,641	243,415	1,649	1,041,202	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,504,034	197,479	96,315	324,549	14.00
15.00 01500	PHARMACY	3,999,930	88,975	241,753	604,575	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,256,663	30,410	0	368,006	16.00
18.00 01850	PHYSICIAN PRIVATE PRACTICE	1,336,483	0	218	388,835	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,457,991	906,359	141,511	1,160,016	30.00
31.00 03100	INTENSIVE CARE UNIT	3,976,962	459,688	161,205	622,314	31.00
43.00 04300	NURSERY	1,713,361	123,226	0	557,696	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,823,563	737,446	1,180,498	1,572,819	50.00
51.00 05100	RECOVERY ROOM	749,751	116,555	468	230,653	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,144,865	218,342	0	372,652	52.00
53.00 05300	ANESTHESIOLOGY	43,155	1,978	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,740,787	258,758	336,684	532,032	54.00
54.01 03630	ULTRA SOUND	725,809	23,969	26,892	201,451	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	73,956	10,397	66,515	5,424	54.02
57.00 05700	CT SCAN	1,157,907	28,293	129,552	148,493	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	401,243	19,943	348,365	76,022	58.00
60.00 06000	LABORATORY	5,826,624	130,219	176,285	580,703	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	289,397	12,122	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	442,768	94,219	4,179	112,797	64.00
65.00 06500	RESPIRATORY THERAPY	1,837,902	76,829	84,025	377,156	65.00
66.00 06600	PHYSICAL THERAPY	1,507,311	288,041	6,925	522,269	66.00
67.00 06700	OCCUPATIONAL THERAPY	497,311	0	3,701	157,976	67.00
68.00 06800	SPEECH PATHOLOGY	324,850	9,063	0	112,588	68.00
69.00 06900	ELECTROCARDIOLOGY	199,881	7,614	15,201	55,882	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	875,811	4,739	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,244,930	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,082,984	0	0	0	73.00
76.00 03952	WOUND CARE (DIABETES CENTER)	500,243	47,892	1,964	154,538	76.00
76.01 03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02 03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03 03950	PAIN MANAGEMENT	556,490	168,932	2,725	154,175	76.03
76.04 03610	SLEEP LAB	429,026	19,345	21,004	106,487	76.04
76.05 03480	ONCOLOGY	2,117,259	337,382	391,263	558,737	76.05
76.97 07697	CARDIAC REHABILITATION	220,530	50,629	14,536	65,625	76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I JACKSON	1,566,039	391,553	19,005	231,999	88.00
88.01 08801	RHC II BROWSTOWN	565,781	69,928	0	123,219	88.01
88.02 08802	RHC III OBGYN	3,076,021	190,693	18,197	297,428	88.02
88.03 08803	RHC IV URGENT CARE	753,846	45,592	800	152,064	88.03
88.04 08804	RHC V SPC IM PEDS	3,190,061	0	1,601	366,444	88.04
88.05 08805	RHC VI JENNING	186,855	34,504	235	23,354	88.05
88.06 08806	RHC VII SCOTT	68,733	13,802	1,346	8,237	88.06
88.07 08807	RHC VIII WASHINGTON CO	215,728	0	0	21,978	88.07
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02 09002	VEIN CENTER	280,057	0	417	45,548	90.02
90.03 09003	OBGYN	0	0	0	0	90.03
90.04 09004	NEUROSURGERY	118,496	0	0	41,436	90.04
90.05 09005	SURGICAL ASSOCIATES	327,254	160,030	926	110,002	90.05
91.00 09100	EMERGENCY	4,414,322	304,097	29,213	1,089,370	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04952	BEHAVIORAL HEALTH	324,382	38,024	0	113,063	93.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1,739,459	36,321	481	565,081	2,341,342	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	950,712	36,321	0	270,286	1,257,319	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	154,330,709	7,589,999	5,181,240	19,717,171	151,765,172
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5,875,382	477,860	20,089	401,749	6,775,080	192.00
194.00 07950 WELLNESS	0	0	0	0	0	194.00
194.01 07951 JACKSON MOB	898,141	0	0	0	898,141	194.01
194.02 07952 EXTERNAL SVCS MARKETING	843,019	44,395	68,684	88,790	1,044,888	194.02
194.03 07953 WASHINGTON CLINIC	563,883	97,095	24,582	57,448	743,008	194.03
194.04 07954 PHYSICIAN OFFICES	1,728,785	105,054	4,127	137,339	1,975,305	194.04
194.05 07955 INTEGRATED MEDICINE	452,400	82,810	0	42,491	577,701	194.05
194.06 07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07 07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08 07958 EMPLOYER CLINIC	804,877	165,735	4,523	192,218	1,167,353	194.08
194.09 07959 UROLOGY PROF	2,947,503	188,669	15,443	207,328	3,358,943	194.09
194.10 07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11 07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12 07962 SPC	0	0	0	0	0	194.12
194.13 07963 PULMONARY PROFESSIONAL	712,594	46,926	1,156	91,026	851,702	194.13
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118 through 201)	169,157,293	8,798,543	5,319,844	20,935,560	169,157,293

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/29/2024 10:24 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,684,099				5.00
7.00	00700	OPERATION OF PLANT	1,043,814	7,185,199			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,647	27,793	610,470		8.00
9.00	00900	HOUSEKEEPING	349,350	42,662	3,414	2,450,863	9.00
10.00	01000	DIETARY	88,546	52,073	0	17,938	679,525 10.00
11.00	01100	CAFETERIA	97,072	107,394	0	36,995	0 11.00
13.00	01300	NURSING ADMINISTRATION	1,114,778	233,789	0	80,535	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	360,728	189,669	0	65,337	0 14.00
15.00	01500	PHARMACY	838,812	85,456	0	29,438	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	281,304	29,207	0	10,061	0 16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	293,279	0	0	0	0 18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,302,923	870,510	332,455	299,870	498,748 30.00
31.00	03100	INTENSIVE CARE UNIT	887,241	441,508	29,652	152,089	180,777 31.00
43.00	04300	NURSERY	406,942	118,353	13,885	40,770	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,432,923	708,282	62,810	243,987	0 50.00
51.00	05100	RECOVERY ROOM	186,523	111,946	0	38,563	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	295,034	209,707	4,965	72,239	0 52.00
53.00	05300	ANESTHESIOLOGY	7,671	1,900	0	655	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,465	248,525	52,008	85,611	0 54.00
54.01	03630	ULTRA SOUND	166,245	23,021	0	7,930	0 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	26,564	9,986	0	3,440	0 54.02
57.00	05700	CT SCAN	248,869	27,174	0	9,361	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,717	19,155	0	6,598	0 58.00
60.00	06000	LABORATORY	1,141,110	125,069	0	43,083	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	51,247	11,643	0	4,011	0 63.00
64.00	06400	INTRAVENOUS THERAPY	111,150	90,493	0	31,173	0 64.00
65.00	06500	RESPIRATORY THERAPY	403,820	73,791	0	25,419	0 65.00
66.00	06600	PHYSICAL THERAPY	395,089	276,650	30,003	95,299	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	112,004	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	75,889	8,705	0	2,999	0 68.00
69.00	06900	ELECTROCARDIOLOGY	47,348	7,313	27,266	2,519	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,551	0	1,568	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,223,636	0	0	0	0 73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	119,763	45,998	0	15,845	0 76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0 76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0 76.02
76.03	03950	PAIN MANAGEMENT	149,963	162,252	0	55,892	0 76.03
76.04	03610	SLEEP LAB	97,876	18,580	0	6,400	0 76.04
76.05	03480	ONCOLOGY	578,666	324,039	0	111,624	0 76.05
76.97	07697	CARDIAC REHABILITATION	59,712	48,627	0	16,751	0 76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	375,382	376,068	0	129,547	0 88.00
88.01	08801	RHC II BROWSTOWN	128,990	67,163	0	23,136	0 88.01
88.02	08802	RHC III OBGYN	608,869	183,152	0	63,091	0 88.02
88.03	08803	RHC IV URGENT CARE	161,857	43,788	0	15,084	0 88.03
88.04	08804	RHC V SPC IM PEDS	604,750	0	0	0	0 88.04
88.05	08805	RHC VI JENNINGS	41,632	33,140	0	11,416	0 88.05
88.06	08806	RHC VII SCOTT	15,657	13,256	0	4,566	0 88.06
88.07	08807	RHC VIII WASHINGTON CO	40,401	0	0	0	0 88.07
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0 90.01
90.02	09002	VEIN CENTER	55,412	0	0	0	0 90.02
90.03	09003	OBGYN	0	0	0	0	0 90.03
90.04	09004	NEUROSURGERY	27,183	0	0	0	0 90.04
90.05	09005	SURGICAL ASSOCIATES	101,675	153,702	0	52,947	0 90.05
91.00	09100	EMERGENCY	992,080	292,070	54,012	100,611	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04952	BEHAVIORAL HEALTH	80,813	36,520	0	12,580	0 93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	397,944	34,885	0	12,017	0 101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
116.00	11600 HOSPICE	213,699	34,885	0	12,017	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	20,728,064	6,024,450	610,470	2,051,012	679,525	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,151,520	458,962	0	158,102	0	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	152,652	0	0	0	0	194.01
194.02	07952 EXTERNAL SVCS MARKETING	177,593	42,640	0	14,688	0	194.02
194.03	07953 WASHINGTON CLINIC	126,285	93,255	0	32,124	0	194.03
194.04	07954 PHYSICIAN OFFICES	335,731	100,899	0	34,757	0	194.04
194.05	07955 INTEGRATED MEDICINE	98,188	79,535	0	27,398	0	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	198,408	159,181	0	54,834	0	194.08
194.09	07959 UROLOGY PROF	570,899	181,207	0	62,422	0	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	144,759	45,070	0	15,526	0	194.13
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	23,684,099	7,185,199	610,470	2,450,863	679,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	812,591					11.00
13.00	01300	NURSING ADMINISTRATION	39,733	8,027,742				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,749	412,247	3,173,107			14.00
15.00	01500	PHARMACY	21,582	391,107	0	6,301,628		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,242	0	0	0	2,000,893	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	17,297	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,567	1,151,928	0	0	70,554	30.00
31.00	03100	INTENSIVE CARE UNIT	31,123	564,001	0	0	29,918	31.00
43.00	04300	NURSERY	21,920	397,217	0	0	51,932	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	71,530	1,296,253	0	0	621,083	50.00
51.00	05100	RECOVERY ROOM	9,391	0	0	0	46,329	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,647	265,419	0	0	61,057	52.00
53.00	05300	ANESTHESIOLOGY	9,871	0	0	0	40,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,722	484,246	0	0	61,648	54.00
54.01	03630	ULTRA SOUND	7,644	0	0	0	28,075	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	131	0	0	0	9,560	54.02
57.00	05700	CT SCAN	5,753	0	0	0	151,184	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,158	0	0	0	53,051	58.00
60.00	06000	LABORATORY	37,736	683,831	0	0	140,742	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	2,685	63.00
64.00	06400	INTRAVENOUS THERAPY	4,757	0	0	0	9,880	64.00
65.00	06500	RESPIRATORY THERAPY	16,081	0	0	0	28,379	65.00
66.00	06600	PHYSICAL THERAPY	25,951	470,269	0	0	34,142	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,482	0	0	0	13,756	67.00
68.00	06800	SPEECH PATHOLOGY	4,059	0	0	0	7,874	68.00
69.00	06900	ELECTROCARDIOLOGY	2,438	44,189	0	0	29,974	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	454,037	0	38,354	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	2,719,070	0	36,157	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,301,628	144,726	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	7,332	0	0	0	8,879	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	12,033	0	0	0	5,696	76.03
76.04	03610	SLEEP LAB	3,425	0	0	0	15,121	76.04
76.05	03480	ONCOLOGY	20,248	0	0	0	58,467	76.05
76.97	07697	CARDIAC REHABILITATION	2,942	0	0	0	1,304	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	8,369	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	0	3,530	88.01
88.02	08802	RHC III OBGYN	22,049	0	0	0	30,169	88.02
88.03	08803	RHC IV URGENT CARE	10,617	192,388	0	0	5,642	88.03
88.04	08804	RHC V SPC IM PEDS	34,494	625,084	0	0	17,810	88.04
88.05	08805	RHC VI JENNINGS	1,909	0	0	0	1,234	88.05
88.06	08806	RHC VII SCOTT	757	0	0	0	473	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	0	945	88.07
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	3,146	0	0	0	7,985	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	4,932	0	0	0	488	90.04
90.05	09005	SURGICAL ASSOCIATES	13,189	0	0	0	1,021	90.05
91.00	09100	EMERGENCY	57,918	1,049,563	0	0	97,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04952	BEHAVIORAL HEALTH	5,910	0	0	0	825	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	11,162	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	12,474	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		690,465	8,027,742	3,173,107	2,000,893	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,775	0	0	0	192.00
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	3,776	0	0	0	194.02
194.03	07953	WASHINGTON CLINIC	7,364	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	17,451	0	0	0	194.04
194.05	07955	INTEGRATED MEDICINE	4,911	0	0	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	11,938	0	0	0	194.08
194.09	07959	UROLOGY PROF	25,559	0	0	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	6,352	0	0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		812,591	8,027,742	3,173,107	2,000,893	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

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

Worksheet B
Part I
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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	PHYSICIAN PRIVATE PRACTICE				
	18.00				
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
18.00 01850	PHYSICIAN PRIVATE PRACTICE	2,036,112			18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	136,137	0	12,392,569	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	7,536,478	31.00
43.00 04300	NURSERY	0	0	3,445,302	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	19,751,194	50.00
51.00 05100	RECOVERY ROOM	0	0	1,490,179	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	2,658,927	52.00
53.00 05300	ANESTHESIOLOGY	0	0	106,209	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	5,484,486	54.00
54.01 03630	ULTRA SOUND	0	0	1,211,036	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	205,973	54.02
57.00 05700	CT SCAN	0	0	1,906,586	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,071,252	58.00
60.00 06000	LABORATORY	0	0	8,885,402	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	371,105	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	901,416	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	2,923,402	65.00
66.00 06600	PHYSICAL THERAPY	0	0	3,651,949	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	791,230	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	546,027	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	439,625	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,379,060	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	8,000,157	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	21,752,974	73.00
76.00 03952	WOUND CARE (DIABETES CENTER)	0	0	902,454	76.00
76.01 03953	OTHER ANCILLARY CMS LINE	0	0	0	76.01
76.02 03951	CASE MANAGEMENT	0	0	0	76.02
76.03 03950	PAIN MANAGEMENT	103,494	0	1,371,652	76.03
76.04 03610	SLEEP LAB	0	0	717,264	76.04
76.05 03480	ONCOLOGY	0	0	4,497,685	76.05
76.97 07697	CARDIAC REHABILITATION	0	0	480,656	76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RHC I JACKSON	171,748	0	3,269,710	88.00
88.01 08801	RHC II BROWSTOWN	52,409	0	1,034,156	88.01
88.02 08802	RHC III OBGYN	189,650	0	4,679,319	88.02
88.03 08803	RHC IV URGENT CARE	91,315	0	1,472,993	88.03
88.04 08804	RHC V SPC IM PEDS	296,690	0	5,136,934	88.04
88.05 08805	RHC VI JENNINGS	0	0	334,279	88.05
88.06 08806	RHC VII SCOTT	0	0	126,827	88.06
88.07 08807	RHC VIII WASHINGTON CO	17,527	0	296,579	88.07
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	PALLIATIVE HEALTH	0	0	0	90.01
90.02 09002	VEIN CENTER	27,056	0	419,621	90.02
90.03 09003	OBGYN	0	0	0	90.03
90.04 09004	NEUROSURGERY	42,421	0	234,956	90.04
90.05 09005	SURGICAL ASSOCIATES	113,445	0	1,034,191	90.05
91.00 09100	EMERGENCY	0	0	8,480,516	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 04952	BEHAVIORAL HEALTH	50,831	0	662,948	93.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
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To 12/31/2023

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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	PHYSICIAN PRIVATE PRACTICE						
	18.00						19.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	0	0	2,797,350	0	2,797,350	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	0		1,530,394	0	1,530,394	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,292,723	0	146,383,022	0	146,383,022	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	385,117	0	8,973,556	0	8,973,556	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	0	0	1,050,793	0	1,050,793	194.01
194.02	07952 EXTERNAL SVCS MARKETING	0	0	1,283,585	0	1,283,585	194.02
194.03	07953 WASHINGTON CLINIC	45,816	0	1,047,852	0	1,047,852	194.03
194.04	07954 PHYSICIAN OFFICES	150,102	0	2,614,245	0	2,614,245	194.04
194.05	07955 INTEGRATED MEDICINE	42,244	0	829,977	0	829,977	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	0	0	1,591,714	0	1,591,714	194.08
194.09	07959 UROLOGY PROF	65,478	0	4,264,508	0	4,264,508	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	54,632	0	1,118,041	0	1,118,041	194.13
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,036,112	0	169,157,293	0	169,157,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	89,849	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	102,730	753,640	1,068,445	5.00
7.00	00700	OPERATION OF PLANT	118,304	473,995	545,338	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,159	28,938	0	8.00
9.00	00900	HOUSEKEEPING	7,978	44,418	14,719	9.00
10.00	01000	DIETARY	4,587	54,218	27,084	10.00
11.00	01100	CAFETERIA	0	111,817	0	11.00
13.00	01300	NURSING ADMINISTRATION	92,008	243,415	1,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,351	197,479	96,315	14.00
15.00	01500	PHARMACY	0	88,975	241,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,410	0	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	0	218	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	137,899	906,359	141,511	30.00
31.00	03100	INTENSIVE CARE UNIT	3,173	459,688	161,205	31.00
43.00	04300	NURSERY	0	123,226	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,852	737,446	1,180,498	50.00
51.00	05100	RECOVERY ROOM	0	116,555	468	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	218,342	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,978	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	258,758	336,684	54.00
54.01	03630	ULTRA SOUND	0	23,969	26,892	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	10,397	66,515	54.02
57.00	05700	CT SCAN	0	28,293	129,552	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,943	348,365	58.00
60.00	06000	LABORATORY	26,073	130,219	176,285	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	12,122	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	94,219	4,179	64.00
65.00	06500	RESPIRATORY THERAPY	0	76,829	84,025	65.00
66.00	06600	PHYSICAL THERAPY	0	288,041	6,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	101	0	3,701	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,063	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,614	15,201	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,739	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	12,996	47,892	1,964	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	0	168,932	2,725	76.03
76.04	03610	SLEEP LAB	2,101	19,345	21,004	76.04
76.05	03480	ONCOLOGY	0	337,382	391,263	76.05
76.97	07697	CARDIAC REHABILITATION	0	50,629	14,536	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I JACKSON	0	391,553	19,005	88.00
88.01	08801	RHC II BROWSTOWN	0	69,928	0	88.01
88.02	08802	RHC III OBGYN	0	190,693	18,197	88.02
88.03	08803	RHC IV URGENT CARE	0	45,592	800	88.03
88.04	08804	RHC V SPC IM PEDI	0	0	1,601	88.04
88.05	08805	RHC VI JENNINGS	0	34,504	235	88.05
88.06	08806	RHC VII SCOTT	13,068	13,802	1,346	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	88.07
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	90.01
90.02	09002	VEIN CENTER	0	0	417	90.02
90.03	09003	OBGYN	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	0	160,030	926	90.05
91.00	09100	EMERGENCY	0	304,097	29,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	0	38,024	0	93.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	36,321	481	36,802	2,425	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	94,020	36,321	0	130,341	1,160	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1,103,400	7,589,999	5,181,240	13,874,639	84,620	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	52,272	477,860	20,089	550,221	1,724	192.00
194.00 07950 WELLNESS	0	0	0	0	0	194.00
194.01 07951 JACKSON MOB	0	0	0	0	0	194.01
194.02 07952 EXTERNAL SVCS MARKETING	0	44,395	68,684	113,079	381	194.02
194.03 07953 WASHINGTON CLINIC	94,127	97,095	24,582	215,804	247	194.03
194.04 07954 PHYSICIAN OFFICES	128,723	105,054	4,127	237,904	589	194.04
194.05 07955 INTEGRATED MEDICINE	0	82,810	0	82,810	182	194.05
194.06 07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07 07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08 07958 EMPLOYER CLINIC	0	165,735	4,523	170,258	825	194.08
194.09 07959 UROLOGY PROF	223,804	188,669	15,443	427,916	890	194.09
194.10 07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11 07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12 07962 SPC	0	0	0	0	0	194.12
194.13 07963 PULMONARY PROFESSIONAL	57,241	46,926	1,156	105,323	391	194.13
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)	1,659,567	8,798,543	5,319,844	15,777,954	89,849	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/29/2024 10:24 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,941,806				5.00
7.00	00700	OPERATION OF PLANT	85,580	1,225,440			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,940	4,740	98,853		8.00
9.00	00900	HOUSEKEEPING	28,643	7,276	553	105,160	9.00
10.00	01000	DIETARY	7,260	8,881	0	770	103,126
11.00	01100	CAFETERIA	7,959	18,316	0	1,587	0
13.00	01300	NURSING ADMINISTRATION	91,398	39,873	0	3,456	0
14.00	01400	CENTRAL SERVICES & SUPPLY	29,575	32,348	0	2,803	0
15.00	01500	PHARMACY	68,772	14,575	0	1,263	0
16.00	01600	MEDICAL RECORDS & LIBRARY	23,064	4,981	0	432	0
18.00	01850	PHYSICIAN PRIVATE PRACTICE	24,045	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	106,824	148,465	53,835	12,863	75,691
31.00	03100	INTENSIVE CARE UNIT	72,743	75,299	4,801	6,526	27,435
43.00	04300	NURSERY	33,364	20,185	2,248	1,749	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	199,464	120,798	10,171	10,469	0
51.00	05100	RECOVERY ROOM	15,293	19,092	0	1,655	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,189	35,766	804	3,100	0
53.00	05300	ANESTHESIOLOGY	629	324	0	28	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,904	42,386	8,422	3,673	0
54.01	03630	ULTRA SOUND	13,630	3,926	0	340	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,178	1,703	0	148	0
57.00	05700	CT SCAN	20,404	4,635	0	402	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,783	3,267	0	283	0
60.00	06000	LABORATORY	93,557	21,331	0	1,849	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,202	1,986	0	172	0
64.00	06400	INTRAVENOUS THERAPY	9,113	15,434	0	1,338	0
65.00	06500	RESPIRATORY THERAPY	33,108	12,585	0	1,091	0
66.00	06600	PHYSICAL THERAPY	32,393	47,183	4,858	4,089	0
67.00	06700	OCCUPATIONAL THERAPY	9,183	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	6,222	1,485	0	129	0
69.00	06900	ELECTROCARDIOLOGY	3,882	1,247	4,415	108	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	776	0	67	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	182,311	0	0	0	0
76.00	03952	WOUND CARE (DIABETES CENTER)	9,819	7,845	0	680	0
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0
76.02	03951	CASE MANAGEMENT	0	0	0	0	0
76.03	03950	PAIN MANAGEMENT	12,295	27,672	0	2,398	0
76.04	03610	SLEEP LAB	8,025	3,169	0	275	0
76.05	03480	ONCOLOGY	47,444	55,265	0	4,789	0
76.97	07697	CARDIAC REHABILITATION	4,896	8,293	0	719	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	30,777	64,139	0	5,559	0
88.01	08801	RHC II BROWSTOWN	10,576	11,455	0	993	0
88.02	08802	RHC III OBGYN	49,920	31,237	0	2,707	0
88.03	08803	RHC IV URGENT CARE	13,270	7,468	0	647	0
88.04	08804	RHC V SPC IM PEDS	49,582	0	0	0	0
88.05	08805	RHC VI JENNINGS	3,413	5,652	0	490	0
88.06	08806	RHC VII SCOTT	1,284	2,261	0	196	0
88.07	08807	RHC VIII WASHINGTON CO	3,312	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0
90.02	09002	VEIN CENTER	4,543	0	0	0	0
90.03	09003	OBGYN	0	0	0	0	0
90.04	09004	NEUROSURGERY	2,229	0	0	0	0
90.05	09005	SURGICAL ASSOCIATES	8,336	26,214	0	2,272	0
91.00	09100	EMERGENCY	81,339	49,813	8,746	4,317	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04952	BEHAVIORAL HEALTH	6,626	6,228	0	540	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	32,627	5,950	0	516	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

Period:
From 01/01/2023
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
116.00	11600 HOSPICE	17,521	5,950	0	516	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,699,446	1,027,474	98,853	88,004	103,126	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	94,411	78,276	0	6,784	0	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	12,516	0	0	0	0	194.01
194.02	07952 EXTERNAL SVCS MARKETING	14,561	7,272	0	630	0	194.02
194.03	07953 WASHINGTON CLINIC	10,354	15,905	0	1,378	0	194.03
194.04	07954 PHYSICIAN OFFICES	27,526	17,208	0	1,491	0	194.04
194.05	07955 INTEGRATED MEDICINE	8,050	13,565	0	1,176	0	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	16,267	27,148	0	2,353	0	194.08
194.09	07959 UROLOGY PROF	46,807	30,905	0	2,678	0	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	11,868	7,687	0	666	0	194.13
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,941,806	1,225,440	98,853	105,160	103,126	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	140,350					11.00
13.00	01300	NURSING ADMINISTRATION	6,863	483,130				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,929	24,810	390,003			14.00
15.00	01500	PHARMACY	3,728	23,538	0	445,198		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,360	0	0	0	64,826	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	2,988	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,979	69,326	0	0	2,294	30.00
31.00	03100	INTENSIVE CARE UNIT	5,376	33,943	0	0	973	31.00
43.00	04300	NURSERY	3,786	23,906	0	0	1,689	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,354	78,012	0	0	19,959	50.00
51.00	05100	RECOVERY ROOM	1,622	0	0	0	1,506	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,530	15,974	0	0	1,985	52.00
53.00	05300	ANESTHESIOLOGY	1,705	0	0	0	1,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,615	29,143	0	0	2,005	54.00
54.01	03630	ULTRA SOUND	1,320	0	0	0	913	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	23	0	0	0	311	54.02
57.00	05700	CT SCAN	994	0	0	0	4,916	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	545	0	0	0	1,725	58.00
60.00	06000	LABORATORY	6,518	41,155	0	0	4,576	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	87	63.00
64.00	06400	INTRAVENOUS THERAPY	822	0	0	0	321	64.00
65.00	06500	RESPIRATORY THERAPY	2,777	0	0	0	923	65.00
66.00	06600	PHYSICAL THERAPY	4,482	28,302	0	0	1,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,120	0	0	0	447	67.00
68.00	06800	SPEECH PATHOLOGY	701	0	0	0	256	68.00
69.00	06900	ELECTROCARDIOLOGY	421	2,659	0	0	975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	55,805	0	1,247	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	334,198	0	1,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	445,198	4,706	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	1,266	0	0	0	289	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	2,078	0	0	0	185	76.03
76.04	03610	SLEEP LAB	592	0	0	0	492	76.04
76.05	03480	ONCOLOGY	3,497	0	0	0	1,901	76.05
76.97	07697	CARDIAC REHABILITATION	508	0	0	0	42	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	272	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	0	115	88.01
88.02	08802	RHC III OBGYN	3,808	0	0	0	981	88.02
88.03	08803	RHC IV URGENT CARE	1,834	11,578	0	0	183	88.03
88.04	08804	RHC V SPC IM PEDS	5,958	37,619	0	0	579	88.04
88.05	08805	RHC VI JENNINGS	330	0	0	0	40	88.05
88.06	08806	RHC VII SCOTT	131	0	0	0	15	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	0	31	88.07
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	543	0	0	0	260	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	852	0	0	0	16	90.04
90.05	09005	SURGICAL ASSOCIATES	2,278	0	0	0	33	90.05
91.00	09100	EMERGENCY	10,004	63,165	0	0	3,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04952	BEHAVIORAL HEALTH	1,021	0	0	0	27	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	363	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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

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Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	406	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		119,258	483,130	390,003	445,198	64,826
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,733	0	0	0	192.00
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	652	0	0	0	194.02
194.03	07953	WASHINGTON CLINIC	1,272	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	3,014	0	0	0	194.04
194.05	07955	INTEGRATED MEDICINE	848	0	0	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	2,062	0	0	0	194.08
194.09	07959	UROLOGY PROF	4,414	0	0	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	1,097	0	0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		140,350	483,130	390,003	445,198	64,826

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

Period:
From 01/01/2023
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Part II
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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	PHYSICIAN PRIVATE PRACTICE					
	18.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
18.00 01850	PHYSICIAN PRIVATE PRACTICE	28,920				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,934	1,672,958	0	1,672,958	30.00
31.00 03100	INTENSIVE CARE UNIT	0	853,833	0	853,833	31.00
43.00 04300	NURSERY	0	212,546	0	212,546	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	2,804,772	0	2,804,772	50.00
51.00 05100	RECOVERY ROOM	0	157,181	0	157,181	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	304,289	0	304,289	52.00
53.00 05300	ANESTHESIOLOGY	0	5,997	0	5,997	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	741,873	0	741,873	54.00
54.01 03630	ULTRA SOUND	0	71,854	0	71,854	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	81,298	0	81,298	54.02
57.00 05700	CT SCAN	0	189,833	0	189,833	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	386,237	0	386,237	58.00
60.00 06000	LABORATORY	0	504,055	0	504,055	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	18,569	0	18,569	63.00
64.00 06400	INTRAVENOUS THERAPY	0	125,910	0	125,910	64.00
65.00 06500	RESPIRATORY THERAPY	0	212,956	0	212,956	65.00
66.00 06600	PHYSICAL THERAPY	0	419,624	0	419,624	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	15,230	0	15,230	67.00
68.00 06800	SPEECH PATHOLOGY	0	18,339	0	18,339	68.00
69.00 06900	ELECTROCARDIOLOGY	0	36,762	0	36,762	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,634	0	62,634	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	335,374	0	335,374	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	632,215	0	632,215	73.00
76.00 03952	WOUND CARE (DIABETES CENTER)	0	83,414	0	83,414	76.00
76.01 03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02 03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03 03950	PAIN MANAGEMENT	1,470	218,417	0	218,417	76.03
76.04 03610	SLEEP LAB	0	55,460	0	55,460	76.04
76.05 03480	ONCOLOGY	0	843,939	0	843,939	76.05
76.97 07697	CARDIAC REHABILITATION	0	79,905	0	79,905	76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I JACKSON	2,439	514,740	0	514,740	88.00
88.01 08801	RHC II BROWSTOWN	744	94,340	0	94,340	88.01
88.02 08802	RHC III OBGYN	2,694	301,513	0	301,513	88.02
88.03 08803	RHC IV URGENT CARE	1,297	83,322	0	83,322	88.03
88.04 08804	RHC V SPC IM PEDS	4,214	101,126	0	101,126	88.04
88.05 08805	RHC VI JENNINGS	0	44,764	0	44,764	88.05
88.06 08806	RHC VII SCOTT	0	32,138	0	32,138	88.06
88.07 08807	RHC VIII WASHINGTON CO	249	3,686	0	3,686	88.07
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02 09002	VEIN CENTER	384	6,342	0	6,342	90.02
90.03 09003	OBGYN	0	0	0	0	90.03
90.04 09004	NEUROSURGERY	603	3,878	0	3,878	90.04
90.05 09005	SURGICAL ASSOCIATES	1,611	202,172	0	202,172	90.05
91.00 09100	EMERGENCY	0	558,532	0	558,532	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04952	BEHAVIORAL HEALTH	722	53,673	0	53,673	93.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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Worksheet B
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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	PHYSICIAN PRIVATE PRACTICE					
	18.00					
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	78,683	0	78,683	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	0	155,894	0	155,894	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18,361	0	13,380,277	0	13,380,277
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	5,470	744,619	0	744,619	192.00
194.00	07950 WELLNESS	0	0	0	0	194.00
194.01	07951 JACKSON MOB	0	12,516	0	12,516	194.01
194.02	07952 EXTERNAL SVCS MARKETING	0	136,575	0	136,575	194.02
194.03	07953 WASHINGTON CLINIC	651	245,611	0	245,611	194.03
194.04	07954 PHYSICIAN OFFICES	2,132	289,864	0	289,864	194.04
194.05	07955 INTEGRATED MEDICINE	600	107,231	0	107,231	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	0	218,913	0	218,913	194.08
194.09	07959 UROLOGY PROF	930	514,540	0	514,540	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	776	127,808	0	127,808	194.13
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	28,920	0	15,777,954	0	15,777,954

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	382,499				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		4,554,264			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,906	0	59,773,918		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	32,763	914,685	11,299,489	-23,684,099	5.00
7.00 00700	OPERATION OF PLANT	20,606	466,858	1,478,977	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,258	0	50,355	0	8.00
9.00 00900	HOUSEKEEPING	1,931	12,601	1,046,407	0	9.00
10.00 01000	DIETARY	2,357	23,186	216,569	0	10.00
11.00 01100	CAFETERIA	4,861	0	446,565	0	11.00
13.00 01300	NURSING ADMINISTRATION	10,582	1,412	2,972,772	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	8,585	82,454	926,632	0	14.00
15.00 01500	PHARMACY	3,868	206,962	1,726,145	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,322	0	1,050,707	0	16.00
18.00 01850	PHYSICIAN PRIVATE PRACTICE	0	187	1,110,178	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	39,402	121,146	3,312,003	0	30.00
31.00 03100	INTENSIVE CARE UNIT	19,984	138,006	1,776,790	0	31.00
43.00 04300	NURSERY	5,357	0	1,592,298	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,059	1,010,612	4,490,613	0	50.00
51.00 05100	RECOVERY ROOM	5,067	401	658,547	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,492	0	1,063,971	0	52.00
53.00 05300	ANESTHESIOLOGY	86	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,249	288,232	1,519,023	0	54.00
54.01 03630	ULTRA SOUND	1,042	23,022	575,171	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	452	56,943	15,485	0	54.02
57.00 05700	CT SCAN	1,230	110,908	423,969	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	867	298,232	217,053	0	58.00
60.00 06000	LABORATORY	5,661	150,916	1,657,987	0	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	527	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	4,096	3,578	322,052	0	64.00
65.00 06500	RESPIRATORY THERAPY	3,340	71,933	1,076,832	0	65.00
66.00 06600	PHYSICAL THERAPY	12,522	5,928	1,491,149	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,168	451,044	0	67.00
68.00 06800	SPEECH PATHOLOGY	394	0	321,455	0	68.00
69.00 06900	ELECTROCARDIOLOGY	331	13,013	159,552	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	206	0	0	-880,550	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	-5,244,930	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03952	WOUND CARE (DIABETES CENTER)	2,082	1,681	441,227	0	76.00
76.01 03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02 03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03 03950	PAIN MANAGEMENT	7,344	2,333	440,190	0	76.03
76.04 03610	SLEEP LAB	841	17,981	304,035	0	76.04
76.05 03480	ONCOLOGY	14,667	334,956	1,595,271	0	76.05
76.97 07697	CARDIAC REHABILITATION	2,201	12,444	187,369	0	76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I JACKSON	17,022	16,270	662,390	0	88.00
88.01 08801	RHC II BROWSTOWN	3,040	0	351,807	0	88.01
88.02 08802	RHC III OBGYN	8,290	15,578	849,198	0	88.02
88.03 08803	RHC IV URGENT CARE	1,982	685	434,164	0	88.03
88.04 08804	RHC V SPC IM PEDS	0	1,371	1,046,247	0	88.04
88.05 08805	RHC VI JENNINGS	1,500	201	66,679	0	88.05
88.06 08806	RHC VII SCOTT	600	1,152	23,517	0	88.06
88.07 08807	RHC VIII WASHINGTON CO	0	0	62,751	0	88.07
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02 09002	VEIN CENTER	0	357	130,047	0	90.02
90.03 09003	OBGYN	0	0	0	0	90.03
90.04 09004	NEUROSURGERY	0	0	118,304	0	90.04
90.05 09005	SURGICAL ASSOCIATES	6,957	793	314,070	0	90.05
91.00 09100	EMERGENCY	13,220	25,009	3,110,301	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 04952	BEHAVIORAL HEALTH	1,653	0	322,810	0	93.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1,579	412	1,613,383	0	2,341,342	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	1,579	0	771,703	0	1,257,319	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	329,960	4,435,606	56,295,253	-29,809,579	121,955,593	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	20,774	17,198	1,147,047	0	6,775,080	192.00
194.00 07950 WELLNESS	0	0	0	0	0	194.00
194.01 07951 JACKSON MOB	0	0	0	0	898,141	194.01
194.02 07952 EXTERNAL SVCS MARKETING	1,930	58,800	253,508	0	1,044,888	194.02
194.03 07953 WASHINGTON CLINIC	4,221	21,044	164,023	0	743,008	194.03
194.04 07954 PHYSICIAN OFFICES	4,567	3,533	392,122	0	1,975,305	194.04
194.05 07955 INTEGRATED MEDICINE	3,600	0	121,317	0	577,701	194.05
194.06 07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07 07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08 07958 EMPLOYER CLINIC	7,205	3,872	548,808	0	1,167,353	194.08
194.09 07959 UROLOGY PROF	8,202	13,221	591,949	0	3,358,943	194.09
194.10 07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11 07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12 07962 SPC	0	0	0	0	0	194.12
194.13 07963 PULMONARY PROFESSIONAL	2,040	990	259,891	0	851,702	194.13
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)	8,798,543	5,319,844	20,935,560		23,684,099	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	23.002787	1.168102	0.350246		0.169964	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			89,849		1,941,806	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001503		0.013935	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: 15-0065

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	325,224				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,258	455,572			8.00
9.00	00900	HOUSEKEEPING	1,931	2,548	322,035		9.00
10.00	01000	DIETARY	2,357	0	2,357	23,730	10.00
11.00	01100	CAFETERIA	4,861	0	4,861	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,582	0	10,582	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,585	0	8,585	0	14.00
15.00	01500	PHARMACY	3,868	0	3,868	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,322	0	1,322	0	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,402	248,099	39,402	17,417	105,003
31.00	03100	INTENSIVE CARE UNIT	19,984	22,128	19,984	6,313	51,411
43.00	04300	NURSERY	5,357	10,362	5,357	0	36,208
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,059	46,873	32,059	0	118,159
51.00	05100	RECOVERY ROOM	5,067	0	5,067	0	15,513
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,492	3,705	9,492	0	24,194
53.00	05300	ANESTHESIOLOGY	86	0	86	0	16,305
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,249	38,812	11,249	0	44,141
54.01	03630	ULTRA SOUND	1,042	0	1,042	0	12,626
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	452	0	452	0	216
57.00	05700	CT SCAN	1,230	0	1,230	0	9,503
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	867	0	867	0	5,216
60.00	06000	LABORATORY	5,661	0	5,661	0	62,334
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	527	0	527	0	0
64.00	06400	INTRAVENOUS THERAPY	4,096	0	4,096	0	7,858
65.00	06500	RESPIRATORY THERAPY	3,340	0	3,340	0	26,563
66.00	06600	PHYSICAL THERAPY	12,522	22,390	12,522	0	42,867
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	10,708
68.00	06800	SPEECH PATHOLOGY	394	0	394	0	6,705
69.00	06900	ELECTROCARDIOLOGY	331	20,348	331	0	4,028
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	206	0	206	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03952	WOUND CARE (DIABETES CENTER)	2,082	0	2,082	0	12,111
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0
76.02	03951	CASE MANAGEMENT	0	0	0	0	0
76.03	03950	PAIN MANAGEMENT	7,344	0	7,344	0	19,876
76.04	03610	SLEEP LAB	841	0	841	0	5,657
76.05	03480	ONCOLOGY	14,667	0	14,667	0	33,447
76.97	07697	CARDIAC REHABILITATION	2,201	0	2,201	0	4,860
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	17,022	0	17,022	0	0
88.01	08801	RHC II BROWSTOWN	3,040	0	3,040	0	0
88.02	08802	RHC III OBGYN	8,290	0	8,290	0	36,422
88.03	08803	RHC IV URGENT CARE	1,982	0	1,982	0	17,537
88.04	08804	RHC V SPC IM PEDS	0	0	0	0	56,979
88.05	08805	RHC VI JENNINGS	1,500	0	1,500	0	3,153
88.06	08806	RHC VII SCOTT	600	0	600	0	1,251
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0
90.02	09002	VEIN CENTER	0	0	0	0	5,196
90.03	09003	OBGYN	0	0	0	0	0
90.04	09004	NEUROSURGERY	0	0	0	0	8,147
90.05	09005	SURGICAL ASSOCIATES	6,957	0	6,957	0	21,787
91.00	09100	EMERGENCY	13,220	40,307	13,220	0	95,672
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04952	BEHAVIORAL HEALTH	1,653	0	1,653	0	9,762
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,579	0	1,579	0	0
102.00	10200	OPIOD TREATMENT PROGRAM	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,579	0	1,579	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	272,685	455,572	269,496	23,730	1,140,545
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,774	0	20,774	0	73,961
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	1,930	0	1,930	0	6,238
194.03	07953	WASHINGTON CLINIC	4,221	0	4,221	0	12,165
194.04	07954	PHYSICIAN OFFICES	4,567	0	4,567	0	28,827
194.05	07955	INTEGRATED MEDICINE	3,600	0	3,600	0	8,113
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	7,205	0	7,205	0	19,720
194.09	07959	UROLOGY PROF	8,202	0	8,202	0	42,219
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	2,040	0	2,040	0	10,492
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,185,199	610,470	2,450,863	679,525	812,591
203.00		Unit cost multiplier (Wkst. B, Part I)	22.093077	1.340008	7.610549	28.635693	0.605381
204.00		Cost to be allocated (per Wkst. B, Part II)	1,225,440	98,853	105,160	103,126	140,350
205.00		Unit cost multiplier (Wkst. B, Part II)	3.767988	0.216987	0.326548	4.345807	0.104561
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: 15-0065

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE	PHYSICIAN PRIVATE PRACTICE (TIME SPENT)	
	13.00	14.00	15.00	16.00		18.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINISTRATION	731,762						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	37,578	6,120,741					14.00
15.00 01500 PHARMACY	35,651	0	100				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	471,417,553			16.00
18.00 01850 PHYSICIAN PRIVATE PRACTICE	0	0	0	0		391,033	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	105,003	0	0	16,624,428		26,145	30.00
31.00 03100 INTENSIVE CARE UNIT	51,411	0	0	7,049,511		0	31.00
43.00 04300 NURSERY	36,208	0	0	12,236,499		0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	118,159	0	0	146,297,035		0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	10,916,431		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	24,194	0	0	14,386,661		0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	9,655,851		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	44,141	0	0	14,525,986		0	54.00
54.01 03630 ULTRA SOUND	0	0	0	6,615,176		0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	2,252,566		0	54.02
57.00 05700 CT SCAN	0	0	0	35,623,104		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,500,194		0	58.00
60.00 06000 LABORATORY	62,334	0	0	33,162,548		0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	632,652		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	2,327,985		0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	6,686,738		0	65.00
66.00 06600 PHYSICAL THERAPY	42,867	0	0	8,044,868		0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,241,336		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,855,388		0	68.00
69.00 06900 ELECTROCARDIOLOGY	4,028	0	0	7,062,593		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	875,811	0	9,037,165		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,244,930	0	8,519,670		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	100	34,101,338		0	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	0	0	2,092,018		0	76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0	0	0	0		0	76.01
76.02 03951 CASE MANAGEMENT	0	0	0	0		0	76.02
76.03 03950 PAIN MANAGEMENT	0	0	0	1,342,094		19,876	76.03
76.04 03610 SLEEP LAB	0	0	0	3,562,853		0	76.04
76.05 03480 ONCOLOGY	0	0	0	13,776,443		0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	307,327		0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0		0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0		0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RHC I JACKSON	0	0	0	1,971,958		32,984	88.00
88.01 08801 RHC II BROWSTOWN	0	0	0	831,796		10,065	88.01
88.02 08802 RHC III OBGYN	0	0	0	7,108,601		36,422	88.02
88.03 08803 RHC IV URGENT CARE	17,537	0	0	1,329,300		17,537	88.03
88.04 08804 RHC V SPC IM Peds	56,979	0	0	4,196,574		56,979	88.04
88.05 08805 RHC VI JENNINGS	0	0	0	290,783		0	88.05
88.06 08806 RHC VII SCOTT	0	0	0	111,533		0	88.06
88.07 08807 RHC VIII WASHINGTON CO	0	0	0	222,744		3,366	88.07
90.00 09000 CLINIC	0	0	0	0		0	90.00
90.01 09001 PALLIATIVE HEALTH	0	0	0	0		0	90.01
90.02 09002 VEIN CENTER	0	0	0	1,881,419		5,196	90.02
90.03 09003 OBGYN	0	0	0	0		0	90.03
90.04 09004 NEUROSURGERY	0	0	0	115,080		8,147	90.04
90.05 09005 SURGICAL ASSOCIATES	0	0	0	240,559		21,787	90.05
91.00 09100 EMERGENCY	95,672	0	0	22,916,947		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		0	92.00
93.00 04952 BEHAVIORAL HEALTH	0	0	0	194,406		9,762	93.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE	
	13.00	14.00	15.00	16.00	18.00	
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	2,630,171	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	0	0	2,939,224	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	731,762	6,120,741	100	471,417,553	248,266	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	73,961	192.00
194.00 07950 WELLNESS	0	0	0	0	0	194.00
194.01 07951 JACKSON MOB	0	0	0	0	0	194.01
194.02 07952 EXTERNAL SVCS MARKETING	0	0	0	0	0	194.02
194.03 07953 WASHINGTON CLINIC	0	0	0	0	8,799	194.03
194.04 07954 PHYSICIAN OFFICES	0	0	0	0	28,827	194.04
194.05 07955 INTEGRATED MEDICINE	0	0	0	0	8,113	194.05
194.06 07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07 07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08 07958 EMPLOYER CLINIC	0	0	0	0	0	194.08
194.09 07959 UROLOGY PROF	0	0	0	0	12,575	194.09
194.10 07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11 07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12 07962 SPC	0	0	0	0	0	194.12
194.13 07963 PULMONARY PROFESSIONAL	0	0	0	0	10,492	194.13
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)	8,027,742	3,173,107	6,301,628	2,000,893	2,036,112	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.970428	0.518419	63,016.280000	0.004244	5.207008	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	483,130	390,003	445,198	64,826	28,920	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.660228	0.063718	4,451.980000	0.000138	0.073958	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: 15-0065

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
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	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	76.01
76.02	03951	CASE MANAGEMENT	76.02
76.03	03950	PAIN MANAGEMENT	76.03
76.04	03610	SLEEP LAB	76.04
76.05	03480	ONCOLOGY	76.05
76.97	07697	CARDIAC REHABILITATION	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I JACKSON	88.00
88.01	08801	RHC II BROWSTOWN	88.01
88.02	08802	RHC III OBGYN	88.02
88.03	08803	RHC IV URGENT CARE	88.03
88.04	08804	RHC V SPC IM PEDS	88.04
88.05	08805	RHC VI JENNINGS	88.05
88.06	08806	RHC VII SCOTT	88.06
88.07	08807	RHC VIII WASHINGTON CO	88.07
90.00	09000	CLINIC	90.00
90.01	09001	PALLIATIVE HEALTH	90.01
90.02	09002	VEIN CENTER	90.02
90.03	09003	OBGYN	90.03
90.04	09004	NEUROSURGERY	90.04
90.05	09005	SURGICAL ASSOCIATES	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04952	BEHAVIORAL HEALTH	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	102.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	WELLNESS	194.00
194.01	07951	JACKSON MOB	194.01
194.02	07952	EXTERNAL SVCS MARKETING	194.02
194.03	07953	WASHINGTON CLINIC	194.03
194.04	07954	PHYSICIAN OFFICES	194.04
194.05	07955	INTEGRATED MEDICINE	194.05
194.06	07956	SURGICAL PROFESSIONAL	194.06
194.07	07957	PRIMARY CARE	194.07
194.08	07958	EMPLOYER CLINIC	194.08
194.09	07959	UROLOGY PROF	194.09
194.10	07960	SCOTTSBURG SPECIAL	194.10
194.11	07961	BEHAVIORAL HEALTH	194.11
194.12	07962	SPC	194.12
194.13	07963	PULMONARY PROFESSIONAL	194.13
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS		12,392,569	72,415	12,464,984	30.00
31.00 03100	INTENSIVE CARE UNIT		7,536,478	15,591	7,552,069	31.00
43.00 04300	NURSERY		3,445,302	0	3,445,302	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM		19,751,194	0	19,751,194	50.00
51.00 05100	RECOVERY ROOM		1,490,179	0	1,490,179	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		2,658,927	0	2,658,927	52.00
53.00 05300	ANESTHESIOLOGY		106,209	0	106,209	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		5,484,486	0	5,484,486	54.00
54.01 03630	ULTRA SOUND		1,211,036	0	1,211,036	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC		205,973	0	205,973	54.02
57.00 05700	CT SCAN		1,906,586	0	1,906,586	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		1,071,252	0	1,071,252	58.00
60.00 06000	LABORATORY		8,885,402	59,723	8,945,125	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.		371,105	0	371,105	63.00
64.00 06400	INTRAVENOUS THERAPY		901,416	0	901,416	64.00
65.00 06500	RESPIRATORY THERAPY	0	2,923,402	0	2,923,402	65.00
66.00 06600	PHYSICAL THERAPY	0	3,651,949	0	3,651,949	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	791,230	0	791,230	67.00
68.00 06800	SPEECH PATHOLOGY	0	546,027	0	546,027	68.00
69.00 06900	ELECTROCARDIOLOGY		439,625	0	439,625	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,379,060	0	1,379,060	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		8,000,157	0	8,000,157	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		21,752,974	0	21,752,974	73.00
76.00 03952	WOUND CARE (DIABETES CENTER)		902,454	0	902,454	76.00
76.01 03953	OTHER ANCILLARY CMS LINE		0	0	0	76.01
76.02 03951	CASE MANAGEMENT		0	0	0	76.02
76.03 03950	PAIN MANAGEMENT		1,371,652	0	1,371,652	76.03
76.04 03610	SLEEP LAB		717,264	0	717,264	76.04
76.05 03480	ONCOLOGY		4,497,685	391,725	4,889,410	76.05
76.97 07697	CARDIAC REHABILITATION		480,656	0	480,656	76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I JACKSON		3,269,710	0	3,269,710	88.00
88.01 08801	RHC II BROWSTOWN		1,034,156	0	1,034,156	88.01
88.02 08802	RHC III OBGYN		4,679,319	0	4,679,319	88.02
88.03 08803	RHC IV URGENT CARE		1,472,993	0	1,472,993	88.03
88.04 08804	RHC V SPC IM Peds		5,136,934	0	5,136,934	88.04
88.05 08805	RHC VI JENNINGS		334,279	0	334,279	88.05
88.06 08806	RHC VII SCOTT		126,827	0	126,827	88.06
88.07 08807	RHC VIII WASHINGTON CO		296,579	0	296,579	88.07
90.00 09000	CLINIC		0	0	0	90.00
90.01 09001	PALLIATIVE HEALTH		0	0	0	90.01
90.02 09002	VEIN CENTER		419,621	4,832	424,453	90.02
90.03 09003	OBGYN		0	0	0	90.03
90.04 09004	NEUROSURGERY		234,956	0	234,956	90.04
90.05 09005	SURGICAL ASSOCIATES		1,034,191	968	1,035,159	90.05
91.00 09100	EMERGENCY		8,480,516	0	8,480,516	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		3,467,494	0	3,467,494	92.00
93.00 04952	BEHAVIORAL HEALTH		662,948	0	662,948	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY		2,797,350	0	2,797,350	101.00
102.00 10200	OPIOID TREATMENT PROGRAM		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		0	0	0	113.00
116.00 11600	HOSPICE		1,530,394	0	1,530,394	116.00
200.00	Subtotal (see instructions)	0	149,850,516	545,254	150,395,770	200.00
201.00	Less Observation Beds		3,467,494	0	3,467,494	201.00
202.00	Total (see instructions)	0	146,383,022	545,254	146,928,276	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,120,400		12,120,400		30.00
31.00	03100	INTENSIVE CARE UNIT	7,049,511		7,049,511		31.00
43.00	04300	NURSERY	12,236,499		12,236,499		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,870,311	137,426,724	146,297,035	0.135007	50.00
51.00	05100	RECOVERY ROOM	626,325	10,290,106	10,916,431	0.136508	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,692,934	693,727	14,386,661	0.184819	52.00
53.00	05300	ANESTHESIOLOGY	793,126	8,862,725	9,655,851	0.010999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,467	14,116,519	14,525,986	0.377564	54.00
54.01	03630	ULTRA SOUND	403,158	6,212,018	6,615,176	0.183069	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	2,252,566	2,252,566	0.091439	54.02
57.00	05700	CT SCAN	1,576,005	34,047,099	35,623,104	0.053521	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	461,684	12,038,510	12,500,194	0.085699	58.00
60.00	06000	LABORATORY	4,402,647	28,759,901	33,162,548	0.267935	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	196,549	436,103	632,652	0.586586	63.00
64.00	06400	INTRAVENOUS THERAPY	374,518	1,953,467	2,327,985	0.387209	64.00
65.00	06500	RESPIRATORY THERAPY	2,993,060	3,693,678	6,686,738	0.437194	65.00
66.00	06600	PHYSICAL THERAPY	443,993	7,600,875	8,044,868	0.453948	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,222	2,902,114	3,241,336	0.244106	67.00
68.00	06800	SPEECH PATHOLOGY	861,732	993,656	1,855,388	0.294293	68.00
69.00	06900	ELECTROCARDIOLOGY	717,624	6,344,969	7,062,593	0.062247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,151,312	7,885,853	9,037,165	0.152599	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	744,157	7,775,513	8,519,670	0.939022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,369,140	31,732,198	34,101,338	0.637892	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	33,856	2,058,162	2,092,018	0.431380	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0.000000	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0.000000	76.02
76.03	03950	PAIN MANAGEMENT	0	1,342,094	1,342,094	1.022024	76.03
76.04	03610	SLEEP LAB	4,291	3,558,562	3,562,853	0.201317	76.04
76.05	03480	ONCOLOGY	49,918	13,726,525	13,776,443	0.326477	76.05
76.97	07697	CARDIAC REHABILITATION	0	307,327	307,327	1.563989	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0	1,971,958	1,971,958		88.00
88.01	08801	RHC II BROWSTOWN	0	831,796	831,796		88.01
88.02	08802	RHC III OBGYN	2,135,634	4,972,967	7,108,601		88.02
88.03	08803	RHC IV URGENT CARE	0	1,329,300	1,329,300		88.03
88.04	08804	RHC V SPC IM PEDS	0	4,196,574	4,196,574		88.04
88.05	08805	RHC VI JENNINGS	0	290,783	290,783		88.05
88.06	08806	RHC VII SCOTT	0	111,533	111,533		88.06
88.07	08807	RHC VIII WASHINGTON CO	0	222,744	222,744		88.07
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0.000000	90.01
90.02	09002	VEIN CENTER	0	1,881,419	1,881,419	0.223034	90.02
90.03	09003	OBGYN	0	0	0	0.000000	90.03
90.04	09004	NEUROSURGERY	0	115,080	115,080	2.041675	90.04
90.05	09005	SURGICAL ASSOCIATES	36,892	203,667	240,559	4.299116	90.05
91.00	09100	EMERGENCY	1,492,342	21,424,605	22,916,947	0.370054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	397,953	4,106,075	4,504,028	0.769865	92.00
93.00	04952	BEHAVIORAL HEALTH	414	193,992	194,406	3.410121	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,630,171	2,630,171		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	2,939,224	2,939,224		116.00
200.00		Subtotal (see instructions)	76,984,674	394,432,879	471,417,553		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	76,984,674	394,432,879	471,417,553		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 10:24 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
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	0.135007		50.00
51.00	05100	RECOVERY ROOM	0.136508		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819		52.00
53.00	05300	ANESTHESIOLOGY	0.010999		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564		54.00
54.01	03630	ULTRA SOUND	0.183069		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439		54.02
57.00	05700	CT SCAN	0.053521		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699		58.00
60.00	06000	LABORATORY	0.269736		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586		63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209		64.00
65.00	06500	RESPIRATORY THERAPY	0.437194		65.00
66.00	06600	PHYSICAL THERAPY	0.453948		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106		67.00
68.00	06800	SPEECH PATHOLOGY	0.294293		68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892		73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380		76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000		76.01
76.02	03951	CASE MANAGEMENT	0.000000		76.02
76.03	03950	PAIN MANAGEMENT	1.022024		76.03
76.04	03610	SLEEP LAB	0.201317		76.04
76.05	03480	ONCOLOGY	0.354911		76.05
76.97	07697	CARDIAC REHABILITATION	1.563989		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON			88.00
88.01	08801	RHC II BROWSTOWN			88.01
88.02	08802	RHC III OBGYN			88.02
88.03	08803	RHC IV URGENT CARE			88.03
88.04	08804	RHC V SPC IM PEDI			88.04
88.05	08805	RHC VI JENNINGS			88.05
88.06	08806	RHC VII SCOTT			88.06
88.07	08807	RHC VIII WASHINGTON CO			88.07
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PALLIATIVE HEALTH	0.000000		90.01
90.02	09002	VEIN CENTER	0.225603		90.02
90.03	09003	OBGYN	0.000000		90.03
90.04	09004	NEUROSURGERY	2.041675		90.04
90.05	09005	SURGICAL ASSOCIATES	4.303140		90.05
91.00	09100	EMERGENCY	0.370054		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865		92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121		93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 10:24 am	
			Title XIX	Hospital	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		12,392,569	72,415	12,464,984	30.00
31.00	03100 INTENSIVE CARE UNIT		7,536,478	15,591	7,552,069	31.00
43.00	04300 NURSERY		3,445,302	0	3,445,302	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		19,751,194	0	19,751,194	50.00
51.00	05100 RECOVERY ROOM		1,490,179	0	1,490,179	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,658,927	0	2,658,927	52.00
53.00	05300 ANESTHESIOLOGY		106,209	0	106,209	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,484,486	0	5,484,486	54.00
54.01	03630 ULTRA SOUND		1,211,036	0	1,211,036	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		205,973	0	205,973	54.02
57.00	05700 CT SCAN		1,906,586	0	1,906,586	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,071,252	0	1,071,252	58.00
60.00	06000 LABORATORY		8,885,402	59,723	8,945,125	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		371,105	0	371,105	63.00
64.00	06400 INTRAVENOUS THERAPY		901,416	0	901,416	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,923,402	0	2,923,402	65.00
66.00	06600 PHYSICAL THERAPY	0	3,651,949	0	3,651,949	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	791,230	0	791,230	67.00
68.00	06800 SPEECH PATHOLOGY	0	546,027	0	546,027	68.00
69.00	06900 ELECTROCARDIOLOGY		439,625	0	439,625	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,379,060	0	1,379,060	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		8,000,157	0	8,000,157	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		21,752,974	0	21,752,974	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)		902,454	0	902,454	76.00
76.01	03953 OTHER ANCILLARY CMS LINE		0	0	0	76.01
76.02	03951 CASE MANAGEMENT		0	0	0	76.02
76.03	03950 PAIN MANAGEMENT		1,371,652	0	1,371,652	76.03
76.04	03610 SLEEP LAB		717,264	0	717,264	76.04
76.05	03480 ONCOLOGY		4,497,685	391,725	4,889,410	76.05
76.97	07697 CARDIAC REHABILITATION		480,656	0	480,656	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC I JACKSON		3,269,710	0	3,269,710	88.00
88.01	08801 RHC II BROWSTOWN		1,034,156	0	1,034,156	88.01
88.02	08802 RHC III OBGYN		4,679,319	0	4,679,319	88.02
88.03	08803 RHC IV URGENT CARE		1,472,993	0	1,472,993	88.03
88.04	08804 RHC V SPC IM Peds		5,136,934	0	5,136,934	88.04
88.05	08805 RHC VI JENNINGS		334,279	0	334,279	88.05
88.06	08806 RHC VII SCOTT		126,827	0	126,827	88.06
88.07	08807 RHC VIII WASHINGTON CO		296,579	0	296,579	88.07
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 PALLIATIVE HEALTH		0	0	0	90.01
90.02	09002 VEIN CENTER		419,621	4,832	424,453	90.02
90.03	09003 OBGYN		0	0	0	90.03
90.04	09004 NEUROSURGERY		234,956	0	234,956	90.04
90.05	09005 SURGICAL ASSOCIATES		1,034,191	968	1,035,159	90.05
91.00	09100 EMERGENCY		8,480,516	0	8,480,516	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,467,494	0	3,467,494	92.00
93.00	04952 BEHAVIORAL HEALTH		662,948	0	662,948	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		2,797,350	0	2,797,350	101.00
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
116.00	11600 HOSPICE		1,530,394	0	1,530,394	116.00
200.00	Subtotal (see instructions)		149,850,516	545,254	150,395,770	200.00
201.00	Less Observation Beds		3,467,494	0	3,467,494	201.00
202.00	Total (see instructions)		146,383,022	545,254	146,928,276	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/29/2024 10:24 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,120,400		12,120,400				30.00
31.00	03100	INTENSIVE CARE UNIT	7,049,511		7,049,511				31.00
43.00	04300	NURSERY	12,236,499		12,236,499				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,870,311	137,426,724	146,297,035	0.135007	0.000000		50.00
51.00	05100	RECOVERY ROOM	626,325	10,290,106	10,916,431	0.136508	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,692,934	693,727	14,386,661	0.184819	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	793,126	8,862,725	9,655,851	0.010999	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,467	14,116,519	14,525,986	0.377564	0.000000		54.00
54.01	03630	ULTRA SOUND	403,158	6,212,018	6,615,176	0.183069	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	2,252,566	2,252,566	0.091439	0.000000		54.02
57.00	05700	CT SCAN	1,576,005	34,047,099	35,623,104	0.053521	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	461,684	12,038,510	12,500,194	0.085699	0.000000		58.00
60.00	06000	LABORATORY	4,402,647	28,759,901	33,162,548	0.267935	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	196,549	436,103	632,652	0.586586	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	374,518	1,953,467	2,327,985	0.387209	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	2,993,060	3,693,678	6,686,738	0.437194	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	443,993	7,600,875	8,044,868	0.453948	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	339,222	2,902,114	3,241,336	0.244106	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	861,732	993,656	1,855,388	0.294293	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	717,624	6,344,969	7,062,593	0.062247	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,151,312	7,885,853	9,037,165	0.152599	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	744,157	7,775,513	8,519,670	0.939022	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,369,140	31,732,198	34,101,338	0.637892	0.000000		73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	33,856	2,058,162	2,092,018	0.431380	0.000000		76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0.000000	0.000000		76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0.000000	0.000000		76.02
76.03	03950	PAIN MANAGEMENT	0	1,342,094	1,342,094	1.022024	0.000000		76.03
76.04	03610	SLEEP LAB	4,291	3,558,562	3,562,853	0.201317	0.000000		76.04
76.05	03480	ONCOLOGY	49,918	13,726,525	13,776,443	0.326477	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0	307,327	307,327	1.563989	0.000000		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON	0	1,971,958	1,971,958	1.658103	0.000000		88.00
88.01	08801	RHC II BROWSTOWN	0	831,796	831,796	1.243281	0.000000		88.01
88.02	08802	RHC III OBGYN	2,135,634	4,972,967	7,108,601	0.658262	0.000000		88.02
88.03	08803	RHC IV URGENT CARE	0	1,329,300	1,329,300	1.108097	0.000000		88.03
88.04	08804	RHC V SPC IM PEDS	0	4,196,574	4,196,574	1.224078	0.000000		88.04
88.05	08805	RHC VI JENNINGS	0	290,783	290,783	1.149582	0.000000		88.05
88.06	08806	RHC VII SCOTT	0	111,533	111,533	1.137125	0.000000		88.06
88.07	08807	RHC VIII WASHINGTON CO	0	222,744	222,744	1.331479	0.000000		88.07
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0.000000	0.000000		90.01
90.02	09002	VEIN CENTER	0	1,881,419	1,881,419	0.223034	0.000000		90.02
90.03	09003	OBGYN	0	0	0	0.000000	0.000000		90.03
90.04	09004	NEUROSURGERY	0	115,080	115,080	2.041675	0.000000		90.04
90.05	09005	SURGICAL ASSOCIATES	36,892	203,667	240,559	4.299116	0.000000		90.05
91.00	09100	EMERGENCY	1,492,342	21,424,605	22,916,947	0.370054	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	397,953	4,106,075	4,504,028	0.769865	0.000000		92.00
93.00	04952	BEHAVIORAL HEALTH	414	193,992	194,406	3.410121	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	2,630,171	2,630,171				101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	2,939,224	2,939,224				116.00
200.00		Subtotal (see instructions)	76,984,674	394,432,879	471,417,553				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	76,984,674	394,432,879	471,417,553				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 10:24 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
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
54.01	03630	ULTRA SOUND	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	54.02
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.000000	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	76.01
76.02	03951	CASE MANAGEMENT	0.000000	76.02
76.03	03950	PAIN MANAGEMENT	0.000000	76.03
76.04	03610	SLEEP LAB	0.000000	76.04
76.05	03480	ONCOLOGY	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I JACKSON	0.000000	88.00
88.01	08801	RHC II BROWSTOWN	0.000000	88.01
88.02	08802	RHC III OBGYN	0.000000	88.02
88.03	08803	RHC IV URGENT CARE	0.000000	88.03
88.04	08804	RHC V SPC IM PEDI	0.000000	88.04
88.05	08805	RHC VI JENNINGS	0.000000	88.05
88.06	08806	RHC VII SCOTT	0.000000	88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000	88.07
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	90.01
90.02	09002	VEIN CENTER	0.000000	90.02
90.03	09003	OBGYN	0.000000	90.03
90.04	09004	NEUROSURGERY	0.000000	90.04
90.05	09005	SURGICAL ASSOCIATES	0.000000	90.05
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04952	BEHAVIORAL HEALTH	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/29/2024 10:24 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,672,958	2,086	1,670,872	7,134	234.21	30.00	
31.00	INTENSIVE CARE UNIT	853,833		853,833	1,894	450.81	31.00	
43.00	NURSERY	212,546		212,546	2,567	82.80	43.00	
200.00	Total (Lines 30 through 199)	2,739,337		2,737,251	11,595		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,202	281,520					30.00
31.00	INTENSIVE CARE UNIT	375	169,054					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30 through 199)	1,577	450,574					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part II Date/Time Prepared: 5/29/2024 10:24 am	
Title XVIII			Hospital		PPS			
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,804,772	146,297,035	0.019172	2,559,762	49,076	50.00
51.00	05100	RECOVERY ROOM	157,181	10,916,431	0.014399	157,343	2,266	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,289	14,386,661	0.021151	854,148	18,066	52.00
53.00	05300	ANESTHESIOLOGY	5,997	9,655,851	0.000621	147,658	92	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	741,873	14,525,986	0.051072	201,379	10,285	54.00
54.01	03630	ULTRA SOUND	71,854	6,615,176	0.010862	79,598	865	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	81,298	2,252,566	0.036091	0	0	54.02
57.00	05700	CT SCAN	189,833	35,623,104	0.005329	794,237	4,232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	386,237	12,500,194	0.030898	158,598	4,900	58.00
60.00	06000	LABORATORY	504,055	33,162,548	0.015200	757,802	11,519	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	18,569	632,652	0.029351	71,436	2,097	63.00
64.00	06400	INTRAVENOUS THERAPY	125,910	2,327,985	0.054085	53,244	2,880	64.00
65.00	06500	RESPIRATORY THERAPY	212,956	6,686,738	0.031848	1,182,536	37,661	65.00
66.00	06600	PHYSICAL THERAPY	419,624	8,044,868	0.052160	189,554	9,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,230	3,241,336	0.004699	162,680	764	67.00
68.00	06800	SPEECH PATHOLOGY	18,339	1,855,388	0.009884	45,311	448	68.00
69.00	06900	ELECTROCARDIOLOGY	36,762	7,062,593	0.005205	308,834	1,607	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,634	9,037,165	0.006931	484,093	3,355	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	335,374	8,519,670	0.039365	252,277	9,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	632,215	34,101,338	0.018539	801,547	14,860	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	83,414	2,092,018	0.039873	5,221	208	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0.000000	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03950	PAIN MANAGEMENT	218,417	1,342,094	0.162743	0	0	76.03
76.04	03610	SLEEP LAB	55,460	3,562,853	0.015566	1,374	21	76.04
76.05	03480	ONCOLOGY	843,939	13,776,443	0.061260	3,660	224	76.05
76.97	07697	CARDIAC REHABILITATION	79,905	307,327	0.260000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	514,740	1,971,958	0.261030	0	0	88.00
88.01	08801	RHC II BROWSTOWN	94,340	831,796	0.113417	0	0	88.01
88.02	08802	RHC III OBGYN	301,513	7,108,601	0.042415	0	0	88.02
88.03	08803	RHC IV URGENT CARE	83,322	1,329,300	0.062681	0	0	88.03
88.04	08804	RHC V SPC IM PEDS	101,126	4,196,574	0.024097	0	0	88.04
88.05	08805	RHC VI JENNINGS	44,764	290,783	0.153943	0	0	88.05
88.06	08806	RHC VII SCOTT	32,138	111,533	0.288148	0	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	3,686	222,744	0.016548	0	0	88.07
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0.000000	0	0	90.01
90.02	09002	VEIN CENTER	6,342	1,881,419	0.003371	0	0	90.02
90.03	09003	OBGYN	0	0	0.000000	0	0	90.03
90.04	09004	NEUROSURGERY	3,878	115,080	0.033698	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	202,172	240,559	0.840426	0	0	90.05
91.00	09100	EMERGENCY	558,532	22,916,947	0.024372	385,179	9,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	465,383	4,504,028	0.103326	54,323	5,613	92.00
93.00	04952	BEHAVIORAL HEALTH	53,673	194,406	0.276087	0	0	93.00
200.00		Total (lines 50 through 199)	10,871,746	434,441,748		9,711,794	200,245	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/29/2024 10:24 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	7,134	0.00	1,202	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,894	0.00	375	31.00	
43.00	04300	NURSERY		0	2,567	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	11,595		1,577	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 10:24 am
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Cost Center Description	Title XVIII			Hospital		PPS
	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
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
54.01 03630 ULTRA SOUND	0	0	0	0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES 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 03952 WOUND CARE (DIABETES CENTER)	0	0	0	0	0	76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02 03951 CASE MANAGEMENT	0	0	0	0	0	76.02
76.03 03950 PAIN MANAGEMENT	0	0	0	0	0	76.03
76.04 03610 SLEEP LAB	0	0	0	0	0	76.04
76.05 03480 ONCOLOGY	0	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RHC I JACKSON	0	0	0	0	0	88.00
88.01 08801 RHC II BROWSTOWN	0	0	0	0	0	88.01
88.02 08802 RHC III OBGYN	0	0	0	0	0	88.02
88.03 08803 RHC IV URGENT CARE	0	0	0	0	0	88.03
88.04 08804 RHC V SPC IM Peds	0	0	0	0	0	88.04
88.05 08805 RHC VI JENNINGS	0	0	0	0	0	88.05
88.06 08806 RHC VII SCOTT	0	0	0	0	0	88.06
88.07 08807 RHC VIII WASHINGTON CO	0	0	0	0	0	88.07
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02 09002 VEIN CENTER	0	0	0	0	0	90.02
90.03 09003 OBGYN	0	0	0	0	0	90.03
90.04 09004 NEUROSURGERY	0	0	0	0	0	90.04
90.05 09005 SURGICAL ASSOCIATES	0	0	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04952 BEHAVIORAL HEALTH	0	0	0	0	0	93.00
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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 10:24 am
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Cost Center Description	Title XVIII			Hospital	PPS	
	All Other Medical Educational Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	146,297,035	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	10,916,431	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	14,386,661	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	9,655,851	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	14,525,986	0.000000	54.00
54.01 03630 ULTRA SOUND	0	0	0	6,615,176	0.000000	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	2,252,566	0.000000	54.02
57.00 05700 CT SCAN	0	0	0	35,623,104	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,500,194	0.000000	58.00
60.00 06000 LABORATORY	0	0	0	33,162,548	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	632,652	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	2,327,985	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	6,686,738	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	8,044,868	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,241,336	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,855,388	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	7,062,593	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,037,165	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	8,519,670	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	34,101,338	0.000000	73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	0	0	2,092,018	0.000000	76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0	0	0	0	0.000000	76.01
76.02 03951 CASE MANAGEMENT	0	0	0	0	0.000000	76.02
76.03 03950 PAIN MANAGEMENT	0	0	0	1,342,094	0.000000	76.03
76.04 03610 SLEEP LAB	0	0	0	3,562,853	0.000000	76.04
76.05 03480 ONCOLOGY	0	0	0	13,776,443	0.000000	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	307,327	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RHC I JACKSON	0	0	0	1,971,958	0.000000	88.00
88.01 08801 RHC II BROWSTOWN	0	0	0	831,796	0.000000	88.01
88.02 08802 RHC III OBGYN	0	0	0	7,108,601	0.000000	88.02
88.03 08803 RHC IV URGENT CARE	0	0	0	1,329,300	0.000000	88.03
88.04 08804 RHC V SPC IM PEDS	0	0	0	4,196,574	0.000000	88.04
88.05 08805 RHC VI JENNINGS	0	0	0	290,783	0.000000	88.05
88.06 08806 RHC VII SCOTT	0	0	0	111,533	0.000000	88.06
88.07 08807 RHC VIII WASHINGTON CO	0	0	0	222,744	0.000000	88.07
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 09001 PALLIATIVE HEALTH	0	0	0	0	0.000000	90.01
90.02 09002 VEIN CENTER	0	0	0	1,881,419	0.000000	90.02
90.03 09003 OBGYN	0	0	0	0	0.000000	90.03
90.04 09004 NEUROSURGERY	0	0	0	115,080	0.000000	90.04
90.05 09005 SURGICAL ASSOCIATES	0	0	0	240,559	0.000000	90.05
91.00 09100 EMERGENCY	0	0	0	22,916,947	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,504,028	0.000000	92.00
93.00 04952 BEHAVIORAL HEALTH	0	0	0	194,406	0.000000	93.00
200.00 Total (lines 50 through 199)	0	0	0	434,441,748		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0065

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		Title XVIII			Hospital		PPS
		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	2,559,762	0	19,627,970	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	157,343	0	1,490,480	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	854,148	0	1,807	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	147,658	0	1,128,840	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	201,379	0	1,691,776	0	54.00
54.01	03630 ULTRA SOUND	0.000000	79,598	0	1,048,749	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	0	491,276	0	54.02
57.00	05700 CT SCAN	0.000000	794,237	0	5,907,092	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	158,598	0	2,039,091	0	58.00
60.00	06000 LABORATORY	0.000000	757,802	0	2,261,680	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	71,436	0	114,343	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	53,244	0	382,245	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,182,536	0	493,174	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	189,554	0	24,655	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	162,680	0	76,812	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	45,311	0	11,352	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	308,834	0	972,935	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	484,093	0	1,115,784	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	252,277	0	1,364,132	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	801,547	0	9,639,697	0	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	0.000000	5,221	0	546,095	0	76.00
76.01	03953 OTHER ANCILLARY CMS LINE	0.000000	0	0	0	0	76.01
76.02	03951 CASE MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03950 PAIN MANAGEMENT	0.000000	0	0	202,505	0	76.03
76.04	03610 SLEEP LAB	0.000000	1,374	0	586,466	0	76.04
76.05	03480 ONCOLOGY	0.000000	3,660	0	4,486,431	0	76.05
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	87,041	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC I JACKSON	0.000000	0	0	0	0	88.00
88.01	08801 RHC II BROWSTOWN	0.000000	0	0	0	0	88.01
88.02	08802 RHC III OBGYN	0.000000	0	0	0	0	88.02
88.03	08803 RHC IV URGENT CARE	0.000000	0	0	0	0	88.03
88.04	08804 RHC V SPC IM PEDS	0.000000	0	0	0	0	88.04
88.05	08805 RHC VI JENNINGS	0.000000	0	0	0	0	88.05
88.06	08806 RHC VII SCOTT	0.000000	0	0	0	0	88.06
88.07	08807 RHC VIII WASHINGTON CO	0.000000	0	0	0	0	88.07
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 PALLIATIVE HEALTH	0.000000	0	0	0	0	90.01
90.02	09002 VEIN CENTER	0.000000	0	0	504,930	0	90.02
90.03	09003 OBGYN	0.000000	0	0	0	0	90.03
90.04	09004 NEUROSURGERY	0.000000	0	0	81,032	0	90.04
90.05	09005 SURGICAL ASSOCIATES	0.000000	0	0	65,510	0	90.05
91.00	09100 EMERGENCY	0.000000	385,179	0	2,517,887	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	54,323	0	809,352	0	92.00
93.00	04952 BEHAVIORAL HEALTH	0.000000	0	0	0	0	93.00
200.00	Total (lines 50 through 199)		9,711,794	0	59,771,139	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 10:24 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.135007	19,627,970	0	0	2,649,913
51.00 05100 RECOVERY ROOM	0.136508	1,490,480	0	0	203,462
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.184819	1,807	0	0	334
53.00 05300 ANESTHESIOLOGY	0.010999	1,128,840	0	0	12,416
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.377564	1,691,776	0	0	638,754
54.01 03630 ULTRA SOUND	0.183069	1,048,749	0	0	191,993
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	491,276	0	0	44,922
57.00 05700 CT SCAN	0.053521	5,907,092	0	0	316,153
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.085699	2,039,091	0	0	174,748
60.00 06000 LABORATORY	0.267935	2,261,680	0	0	605,983
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.586586	114,343	0	0	67,072
64.00 06400 INTRAVENOUS THERAPY	0.387209	382,245	0	0	148,009
65.00 06500 RESPIRATORY THERAPY	0.437194	493,174	0	0	215,613
66.00 06600 PHYSICAL THERAPY	0.453948	24,655	0	0	11,192
67.00 06700 OCCUPATIONAL THERAPY	0.244106	76,812	0	0	18,750
68.00 06800 SPEECH PATHOLOGY	0.294293	11,352	0	0	3,341
69.00 06900 ELECTROCARDIOLOGY	0.062247	972,935	0	0	60,562
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	1,115,784	0	0	170,268
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	1,364,132	0	0	1,280,950
73.00 07300 DRUGS CHARGED TO PATIENTS	0.637892	9,639,697	0	1,372	6,149,086
76.00 03952 WOUND CARE (DIABETES CENTER)	0.431380	546,095	0	0	235,574
76.01 03953 OTHER ANCILLARY CMS LINE	0.000000	0	0	0	0
76.02 03951 CASE MANAGEMENT	0.000000	0	0	0	0
76.03 03950 PAIN MANAGEMENT	1.022024	202,505	0	0	206,965
76.04 03610 SLEEP LAB	0.201317	586,466	0	0	118,066
76.05 03480 ONCOLOGY	0.326477	4,486,431	0	0	1,464,717
76.97 07697 CARDIAC REHABILITATION	1.563989	87,041	0	0	136,131
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RHC I JACKSON					
88.01 08801 RHC II BROWSTOWN					
88.02 08802 RHC III OBGYN					
88.03 08803 RHC IV URGENT CARE					
88.04 08804 RHC V SPC IM PEDS					
88.05 08805 RHC VI JENNINGS					
88.06 08806 RHC VII SCOTT					
88.07 08807 RHC VIII WASHINGTON CO					
90.00 09000 CLINIC	0.000000	0	0	0	0
90.01 09001 PALLIATIVE HEALTH	0.000000	0	0	0	0
90.02 09002 VEIN CENTER	0.223034	504,930	0	0	112,617
90.03 09003 OBGYN	0.000000	0	0	0	0
90.04 09004 NEUROSURGERY	2.041675	81,032	0	0	165,441
90.05 09005 SURGICAL ASSOCIATES	4.299116	65,510	0	0	281,635
91.00 09100 EMERGENCY	0.370054	2,517,887	0	0	931,754
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	809,352	0	0	623,092
93.00 04952 BEHAVIORAL HEALTH	3.410121	0	0	0	0
200.00 Subtotal (see instructions)		59,771,139	0	1,372	17,239,513
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 - line 201)		59,771,139	0	1,372	17,239,513

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	875		73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	0		76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0	0		76.01
76.02 03951 CASE MANAGEMENT	0	0		76.02
76.03 03950 PAIN MANAGEMENT	0	0		76.03
76.04 03610 SLEEP LAB	0	0		76.04
76.05 03480 ONCOLOGY	0	0		76.05
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC I JACKSON				88.00
88.01 08801 RHC II BROWSTOWN				88.01
88.02 08802 RHC III OBGYN				88.02
88.03 08803 RHC IV URGENT CARE				88.03
88.04 08804 RHC V SPC IM PEDS				88.04
88.05 08805 RHC VI JENNINGS				88.05
88.06 08806 RHC VII SCOTT				88.06
88.07 08807 RHC VIII WASHINGTON CO				88.07
90.00 09000 CLINIC	0	0		90.00
90.01 09001 PALLIATIVE HEALTH	0	0		90.01
90.02 09002 VEIN CENTER	0	0		90.02
90.03 09003 OBGYN	0	0		90.03
90.04 09004 NEUROSURGERY	0	0		90.04
90.05 09005 SURGICAL ASSOCIATES	0	0		90.05
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04952 BEHAVIORAL HEALTH	0	0		93.00
200.00 Subtotal (see instructions)	0	875		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	875		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 10:24 am
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.135007	0	0	2,480,572	0	50.00
51.00	05100	RECOVERY ROOM	0.136508	0	0	251,104	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819	0	0	42,735	0	52.00
53.00	05300	ANESTHESIOLOGY	0.010999	0	0	167,261	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564	0	0	238,198	0	54.00
54.01	03630	ULTRA SOUND	0.183069	0	0	136,794	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	0	0	27,923	0	54.02
57.00	05700	CT SCAN	0.053521	0	0	674,568	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699	0	0	214,307	0	58.00
60.00	06000	LABORATORY	0.267935	0	0	593,530	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586	0	0	6,690	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209	0	0	31,673	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.437194	0	0	74,700	0	65.00
66.00	06600	PHYSICAL THERAPY	0.453948	0	0	111,240	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106	0	0	60,841	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294293	0	0	48,688	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247	0	0	103,858	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	0	0	244,562	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892	0	0	408,228	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380	0	0	33,508	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1.022024	0	0	21,590	0	76.03
76.04	03610	SLEEP LAB	0.201317	0	0	64,140	0	76.04
76.05	03480	ONCOLOGY	0.326477	0	0	108,709	0	76.05
76.97	07697	CARDIAC REHABILITATION	1.563989	0	0	2,232	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON						88.00
88.01	08801	RHC II BROWSTOWN						88.01
88.02	08802	RHC III OBGYN						88.02
88.03	08803	RHC IV URGENT CARE						88.03
88.04	08804	RHC V SPC IM PEDS						88.04
88.05	08805	RHC VI JENNINGS						88.05
88.06	08806	RHC VII SCOTT						88.06
88.07	08807	RHC VIII WASHINGTON CO						88.07
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0.223034	0	0	43,213	0	90.02
90.03	09003	OBGYN	0.000000	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	2.041675	0	0	7,939	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.299116	0	0	4,611	0	90.05
91.00	09100	EMERGENCY	0.370054	0	0	773,099	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	0	0	101,476	0	92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121	0	0	19,882	0	93.00
200.00		Subtotal (see instructions)		0	0	7,097,871	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	7,097,871	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 10:24 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	334,895		50.00
51.00 05100 RECOVERY ROOM	0	34,278		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	7,898		52.00
53.00 05300 ANESTHESIOLOGY	0	1,840		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	89,935		54.00
54.01 03630 ULTRA SOUND	0	25,043		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2,553		54.02
57.00 05700 CT SCAN	0	36,104		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	18,366		58.00
60.00 06000 LABORATORY	0	159,027		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	3,924		63.00
64.00 06400 INTRAVENOUS THERAPY	0	12,264		64.00
65.00 06500 RESPIRATORY THERAPY	0	32,658		65.00
66.00 06600 PHYSICAL THERAPY	0	50,497		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	14,852		67.00
68.00 06800 SPEECH PATHOLOGY	0	14,329		68.00
69.00 06900 ELECTROCARDIOLOGY	0	6,465		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37,320		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	260,405		73.00
76.00 03952 WOUND CARE (DIABETES CENTER)	0	14,455		76.00
76.01 03953 OTHER ANCILLARY CMS LINE	0	0		76.01
76.02 03951 CASE MANAGEMENT	0	0		76.02
76.03 03950 PAIN MANAGEMENT	0	22,065		76.03
76.04 03610 SLEEP LAB	0	12,912		76.04
76.05 03480 ONCOLOGY	0	35,491		76.05
76.97 07697 CARDIAC REHABILITATION	0	3,491		76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC I JACKSON				88.00
88.01 08801 RHC II BROWSTOWN				88.01
88.02 08802 RHC III OBGYN				88.02
88.03 08803 RHC IV URGENT CARE				88.03
88.04 08804 RHC V SPC IM PEDS				88.04
88.05 08805 RHC VI JENNINGS				88.05
88.06 08806 RHC VII SCOTT				88.06
88.07 08807 RHC VIII WASHINGTON CO				88.07
90.00 09000 CLINIC	0	0		90.00
90.01 09001 PALLIATIVE HEALTH	0	0		90.01
90.02 09002 VEIN CENTER	0	9,638		90.02
90.03 09003 OBGYN	0	0		90.03
90.04 09004 NEUROSURGERY	0	16,209		90.04
90.05 09005 SURGICAL ASSOCIATES	0	19,823		90.05
91.00 09100 EMERGENCY	0	286,088		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	78,123		92.00
93.00 04952 BEHAVIORAL HEALTH	0	67,800		93.00
200.00 Subtotal (see instructions)	0	1,708,748		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	1,708,748		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 10:24 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,194	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,134	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)		5,147	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		60	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,202	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)		12	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		259.03	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		259.03	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,464,984	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)		15,542	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)		15,542	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,449,442	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,449,442	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,745.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,097,598	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,097,598	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,552,069	1,894	3,987.36	375	1,495,260	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)					2,625,751	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)					6,218,609	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)					450,574	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					200,245	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					650,819	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					5,567,790	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)					3,108	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					3,108	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,987	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,745.09	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/29/2024 10:24 am		
		Title XVIII		Hospital		PPS		
Cost Center Description						1.00		
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,467,494		89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	1,672,958	12,464,984	0.134213	3,467,494	465,383	90.00	
91.00	Nursing Program cost	0	12,464,984	0.000000	3,467,494	0	91.00	
92.00	Allied health cost	0	12,464,984	0.000000	3,467,494	0	92.00	
93.00	All other Medical Education	0	12,464,984	0.000000	3,467,494	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2024 10:24 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,194	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,134	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)		5,147	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		60	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,527	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)		2,567	15.00
16.00	Nursery days (title V or XIX only)		1,619	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		259.03	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		259.03	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,392,569	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)		15,542	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)		15,542	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,377,027	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,377,027	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,734.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,649,253	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,649,253	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 10:24 am		
Cost Center Description			Title XIX	Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	3,445,302	2,567	1,342.15	1,619	2,172,941	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,536,478	1,894	3,979.13	209	831,638	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)					989,806	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)					6,643,638	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 anesthesiologist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,987	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,734.94	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description		Title XIX		Hospital		Cost	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1.00	89.00
						3,447,326	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,672,958	12,392,569	0.134997	3,447,326	465,379	90.00
91.00	Nursing Program cost	0	12,392,569	0.000000	3,447,326	0	91.00
92.00	Allied health cost	0	12,392,569	0.000000	3,447,326	0	92.00
93.00	All other Medical Education	0	12,392,569	0.000000	3,447,326	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,403,939	30.00
31.00	03100	INTENSIVE CARE UNIT		2,214,787	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.135007	2,559,762	345,586 50.00
51.00	05100	RECOVERY ROOM	0.136508	157,343	21,479 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819	854,148	157,863 52.00
53.00	05300	ANESTHESIOLOGY	0.010999	147,658	1,624 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564	201,379	76,033 54.00
54.01	03630	ULTRA SOUND	0.183069	79,598	14,572 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	0	0 54.02
57.00	05700	CT SCAN	0.053521	794,237	42,508 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699	158,598	13,592 58.00
60.00	06000	LABORATORY	0.269736	757,802	204,406 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586	71,436	41,903 63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209	53,244	20,617 64.00
65.00	06500	RESPIRATORY THERAPY	0.437194	1,182,536	516,998 65.00
66.00	06600	PHYSICAL THERAPY	0.453948	189,554	86,048 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106	162,680	39,711 67.00
68.00	06800	SPEECH PATHOLOGY	0.294293	45,311	13,335 68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247	308,834	19,224 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	484,093	73,872 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	252,277	236,894 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892	801,547	511,300 73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380	5,221	2,252 76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	0 76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	0 76.02
76.03	03950	PAIN MANAGEMENT	1.022024	0	0 76.03
76.04	03610	SLEEP LAB	0.201317	1,374	277 76.04
76.05	03480	ONCOLOGY	0.354911	3,660	1,299 76.05
76.97	07697	CARDIAC REHABILITATION	1.563989	0	0 76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0.000000		0 88.00
88.01	08801	RHC II BROWSTOWN	0.000000		0 88.01
88.02	08802	RHC III OBGYN	0.000000		0 88.02
88.03	08803	RHC IV URGENT CARE	0.000000		0 88.03
88.04	08804	RHC V SPC IM PEDS	0.000000		0 88.04
88.05	08805	RHC VI JENNINGS	0.000000		0 88.05
88.06	08806	RHC VII SCOTT	0.000000		0 88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000		0 88.07
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	0 90.01
90.02	09002	VEIN CENTER	0.225603	0	0 90.02
90.03	09003	OBGYN	0.000000	0	0 90.03
90.04	09004	NEUROSURGERY	2.041675	0	0 90.04
90.05	09005	SURGICAL ASSOCIATES	4.303140	0	0 90.05
91.00	09100	EMERGENCY	0.370054	385,179	142,537 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	54,323	41,821 92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121	0	0 93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,711,794	2,625,751 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		9,711,794	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 15-U065		Date/Time Prepared: 5/29/2024 10:24 am	
		Title XVIII	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	0.135007	0	50.00
51.00	05100	RECOVERY ROOM	0.136508	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819	0	52.00
53.00	05300	ANESTHESIOLOGY	0.010999	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564	0	54.00
54.01	03630	ULTRA SOUND	0.183069	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	0	54.02
57.00	05700	CT SCAN	0.053521	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699	0	58.00
60.00	06000	LABORATORY	0.269736	1,114	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.437194	0	65.00
66.00	06600	PHYSICAL THERAPY	0.453948	3,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294293	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	287	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892	3,221	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	76.02
76.03	03950	PAIN MANAGEMENT	1.022024	0	76.03
76.04	03610	SLEEP LAB	0.201317	0	76.04
76.05	03480	ONCOLOGY	0.354911	0	76.05
76.97	07697	CARDIAC REHABILITATION	1.563989	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0.000000		88.00
88.01	08801	RHC II BROWSTOWN	0.000000		88.01
88.02	08802	RHC III OBGYN	0.000000		88.02
88.03	08803	RHC IV URGENT CARE	0.000000		88.03
88.04	08804	RHC V SPC IM PEDS	0.000000		88.04
88.05	08805	RHC VI JENNINGS	0.000000		88.05
88.06	08806	RHC VII SCOTT	0.000000		88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000		88.07
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	90.01
90.02	09002	VEIN CENTER	0.225603	0	90.02
90.03	09003	OBGYN	0.000000	0	90.03
90.04	09004	NEUROSURGERY	2.041675	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.303140	0	90.05
91.00	09100	EMERGENCY	0.370054	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	0	92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,941	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)		7,941	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,084,012	30.00
31.00	03100	INTENSIVE CARE UNIT		432,800	31.00
43.00	04300	NURSERY		2,901,979	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.135007	380,878	50.00
51.00	05100	RECOVERY ROOM	0.136508	36,232	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819	2,227,273	52.00
53.00	05300	ANESTHESIOLOGY	0.010999	77,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564	23,399	54.00
54.01	03630	ULTRA SOUND	0.183069	42,097	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	0	54.02
57.00	05700	CT SCAN	0.053521	93,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699	26,070	58.00
60.00	06000	LABORATORY	0.267935	607,528	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586	19,458	63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209	9,513	64.00
65.00	06500	RESPIRATORY THERAPY	0.437194	180,402	65.00
66.00	06600	PHYSICAL THERAPY	0.453948	22,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106	11,064	67.00
68.00	06800	SPEECH PATHOLOGY	0.294293	26,528	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247	54,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	59,152	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892	209,253	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380	1,889	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	76.02
76.03	03950	PAIN MANAGEMENT	1.022024	0	76.03
76.04	03610	SLEEP LAB	0.201317	0	76.04
76.05	03480	ONCOLOGY	0.326477	4,785	76.05
76.97	07697	CARDIAC REHABILITATION	1.563989	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	1.658103	0	88.00
88.01	08801	RHC II BROWSTOWN	1.243281	0	88.01
88.02	08802	RHC III OBGYN	0.658262	0	88.02
88.03	08803	RHC IV URGENT CARE	1.108097	0	88.03
88.04	08804	RHC V SPC IM PEDS	1.224078	0	88.04
88.05	08805	RHC VI JENNINGS	1.149582	0	88.05
88.06	08806	RHC VII SCOTT	1.137125	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	1.331479	0	88.07
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	90.01
90.02	09002	VEIN CENTER	0.223034	0	90.02
90.03	09003	OBGYN	0.000000	0	90.03
90.04	09004	NEUROSURGERY	2.041675	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.299116	9,949	90.05
91.00	09100	EMERGENCY	0.370054	74,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	0	92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121	414	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,196,903	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		4,196,903	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 15-U065		Date/Time Prepared: 5/29/2024 10:24 am	
Cost Center Description		Title XIX	Swing Beds - NF	Cost	
		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	0.135007	0	50.00
51.00	05100	RECOVERY ROOM	0.136508	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.184819	0	52.00
53.00	05300	ANESTHESIOLOGY	0.010999	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377564	0	54.00
54.01	03630	ULTRA SOUND	0.183069	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.091439	0	54.02
57.00	05700	CT SCAN	0.053521	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.085699	0	58.00
60.00	06000	LABORATORY	0.267935	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586586	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.387209	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.437194	0	65.00
66.00	06600	PHYSICAL THERAPY	0.453948	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.244106	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294293	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062247	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152599	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.939022	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637892	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.431380	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	76.02
76.03	03950	PAIN MANAGEMENT	1.022024	0	76.03
76.04	03610	SLEEP LAB	0.201317	0	76.04
76.05	03480	ONCOLOGY	0.326477	0	76.05
76.97	07697	CARDIAC REHABILITATION	1.563989	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	1.658103	0	88.00
88.01	08801	RHC II BROWSTOWN	1.243281	0	88.01
88.02	08802	RHC III OBGYN	0.658262	0	88.02
88.03	08803	RHC IV URGENT CARE	1.108097	0	88.03
88.04	08804	RHC V SPC IM PEDS	1.224078	0	88.04
88.05	08805	RHC VI JENNINGS	1.149582	0	88.05
88.06	08806	RHC VII SCOTT	1.137125	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	1.331479	0	88.07
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	90.01
90.02	09002	VEIN CENTER	0.223034	0	90.02
90.03	09003	OBGYN	0.000000	0	90.03
90.04	09004	NEUROSURGERY	2.041675	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.299116	0	90.05
91.00	09100	EMERGENCY	0.370054	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769865	0	92.00
93.00	04952	BEHAVIORAL HEALTH	3.410121	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,729,699	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,001,067	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		75,225	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		1,301,897	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		46.39	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)		38.65	31.00
32.00	Sum of lines 30 and 31		41.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00

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		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			111,923	34.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Payment Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		1,161,201	944,511	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		868,514	237,418	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,105,932		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		5,023,846		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			5,023,846	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			292,206	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			11,547	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			5,327,599	59.00
60.00	Primary payer payments			13,027	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,314,572	61.00
62.00	Deductibles billed to program beneficiaries			457,336	62.00
63.00	Coinsurance billed to program beneficiaries			1,600	63.00
64.00	Allowable bad debts (see instructions)			34,441	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			22,387	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,533	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,878,023	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			5,393	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	498,321	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2024	177,003	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,558,740	71.00
71.01	Sequestration adjustment (see instructions)		111,175	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		4,896,867	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		550,698	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		318,316	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0 95.00
96.00	Time value of money for capital related expenses (see instructions)			0 96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0 102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0 104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0065

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,729,699	0	2,729,699		2,729,699	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,001,067	0		1,001,067	1,001,067	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	75,225	0	75,225		75,225	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,301,897	0	1,301,897	0	1,301,897	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,923	0	81,891	30,032	111,923	11.00
11.01	Uncompensated care payments	36.00	1,105,932	0	868,514	237,418	1,105,932	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,023,846	0	3,755,329	1,268,517	5,023,846	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,023,846	0	3,755,329	1,268,517	5,023,846	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0065

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	292,206	0	214,849	77,357	292,206	16.00
17.00	Special add-on payments for new technologies	54.00	11,547	0	11,547	0	11,547	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,981,725	1,345,874	5,327,599	19.00
	W/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	283,102	0	205,745	77,357	283,102	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,104	0	9,104	0	9,104	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	292,206	0	214,849	77,357	292,206	26.00
	W/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.125152	0.131515			27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96		498,321			498,321	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97			177,003		177,003	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 10:24 am
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		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,729,699	2,729,699		2,729,699	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,001,067		1,001,067	1,001,067	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	75,225	75,225		75,225	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,301,897	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,923	81,891	30,032	111,923	11.00
11.01	Uncompensated care payments	36.00	1,105,932	868,514	237,418	1,105,932	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,023,846	3,755,329	1,268,517	5,023,846	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,023,846	3,755,329	1,268,517	5,023,846	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	292,206	214,849	77,357	292,206	16.00
17.00	Special add-on payments for new technologies	54.00	11,547	11,547	0	11,547	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,981,725	1,345,874	5,327,599	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 10:24 am
Title XVIII			Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	283,102	205,745	77,357	283,102	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,104	9,104	0	9,104	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	292,206	214,849	77,357	292,206	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	498,321	498,321		498,321	27.00
28.00	Low volume adjustment prior to October 1	70.96					28.00
29.00	Low volume adjustment on or after October 1	70.97	177,003		177,003	177,003	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	5,393	0	5,393	5,393	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		875	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		17,239,513	2.00
3.00	OPPTS or REH payments		15,508,361	3.00
4.00	Outlier payment (see instructions)		98,763	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		875	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,372	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)		1,372	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 charge basis 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)		1,372	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		497	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)		875	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)		15,607,124	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,690,974	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)		12,917,025	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		12,917,025	30.00
31.00	Primary payer payments		4,161	31.00
32.00	Subtotal (line 30 minus line 31)		12,912,864	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)		239,034	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		155,372	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		191,376	36.00
37.00	Subtotal (see instructions)		13,068,236	37.00
38.00	MSP-LCC reconciliation amount from PS&R		44	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		13,068,192	40.00
40.01	Sequestration adjustment (see instructions)		261,364	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		12,767,144	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)		39,684	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		83,662	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0065

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,860,867		12,767,144	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/01/2023	36,000		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		36,000		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,896,867		12,767,144	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		550,698		39,684	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,447,565		12,806,828	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: 15-0065

Period: From 01/01/2023

Worksheet E-1

Component CCN: 15-U065

To 12/31/2023

Part I
Date/Time Prepared:
5/29/2024 10:24 am

Title XVIII

Swing Beds - SNF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,655		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)		3,655		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		3,654		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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & 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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E-2
		Component CCN: 15-U065	Date/Time Prepared: 5/29/2024 10:24 am	
		Title XVIII	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)	4,929	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)	0	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	12	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)	4,929	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	4,929	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)	4,929	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,200	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,729	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)	3,729	0	19.00
19.01	Sequestration adjustment (see instructions)	75	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	3,655	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)	-1	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
Comparison 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: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E-2
		Component CCN: 15-U065	Date/Time Prepared: 5/29/2024 10:24 am	
		Title XIX	Swing Beds - NF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	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	Coinurance 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
Comparison 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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/29/2024 10:24 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0065

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

Worksheet G

Date/Time Prepared:
5/29/2024 10:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	84,500,921	0	0	0	1.00
2.00	Temporary investments	25,000,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	75,641,749	0	0	0	4.00
5.00	Other receivable	3,385,534	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-56,635,054	0	0	0	6.00
7.00	Inventory	5,861,227	0	0	0	7.00
8.00	Prepaid expenses	2,715,546	0	0	0	8.00
9.00	Other current assets	24,348,244	0	0	0	9.00
10.00	Due from other funds	-9,407,331	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	155,410,836	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,751,025	0	0	0	12.00
13.00	Land improvements	5,008,060	0	0	0	13.00
14.00	Accumulated depreciation	-3,506,935	0	0	0	14.00
15.00	Buildings	155,987,896	0	0	0	15.00
16.00	Accumulated depreciation	-77,114,426	0	0	0	16.00
17.00	Leasehold improvements	6,713,021	0	0	0	17.00
18.00	Accumulated depreciation	-94,659	0	0	0	18.00
19.00	Fixed equipment	9,452,816	0	0	0	19.00
20.00	Accumulated depreciation	-6,095,354	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	65,085,034	0	0	0	23.00
24.00	Accumulated depreciation	-46,152,186	0	0	0	24.00
25.00	Minor equipment depreciable	11,743,459	0	0	0	25.00
26.00	Accumulated depreciation	-7,543,587	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)	125,234,164	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	11,026,835	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	232,416,909	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	243,443,744	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	524,088,744	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,379,335	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,384,928	0	0	0	38.00
39.00	Payroll taxes payable	48,607	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,602,543	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,415,413	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	21,551,661	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	17,559,954	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,111,615	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	64,527,028	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	459,561,716				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)	459,561,716	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	524,088,744	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0065

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

Worksheet G-1

Date/Time Prepared:
5/29/2024 10:24 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		433,413,049		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,148,667		0		2.00
3.00	Total (sum of line 1 and line 2)		459,561,716		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)		459,561,716		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)		459,561,716		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: 15-0065

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2024 10:24 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,150,558		12,150,558	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,150,558		12,150,558	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,318,820		7,318,820	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)	7,318,820		7,318,820	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,469,378		19,469,378	17.00
18.00	Ancillary services	54,721,710	366,982,172	421,703,882	18.00
19.00	Outpatient services	4,207,702	35,831,040	40,038,742	19.00
20.00	RHC I JACKSON	0	1,971,958	1,971,958	20.00
20.01	RHC II BROWSTOWN	0	831,796	831,796	20.01
20.02	RHC III OBGYN	2,135,634	4,972,967	7,108,601	20.02
20.03	RHC IV URGENT CARE	0	1,329,300	1,329,300	20.03
20.04	RHC V SPC IM Peds	0	4,196,574	4,196,574	20.04
20.05	RHC VI JENNINGS	0	0	0	20.05
20.06	RHC VII SCOTT	0	0	0	20.06
20.07	RHC VIII WASHINGTON CO	0	0	0	20.07
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,630,171	2,630,171	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	2,939,224	2,939,224	26.00
27.00	OTHER OUTPATIENT	834,401	27,171,213	28,005,614	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	81,368,825	448,856,415	530,225,240	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		199,579,172		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)		199,579,172		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0065

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

Worksheet G-3

Date/Time Prepared:
5/29/2024 10:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	530,225,240	1.00
2.00	Less contractual allowances and discounts on patients' accounts	326,936,241	2.00
3.00	Net patient revenues (line 1 minus line 2)	203,288,999	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	199,579,172	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,709,827	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	578,196	6.00
7.00	Income from investments	18,716,700	7.00
8.00	Revenues from telephone and other miscellaneous communication services	2,144	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	72,015	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	530,047	14.00
15.00	Revenue from rental of living quarters	633,953	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	655,770	17.00
18.00	Revenue from sale of medical records and abstracts	15,372	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	5,400	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	90,893	22.00
23.00	Governmental appropriations	0	23.00
24.00	CONTRACT REVENUE	339,832	24.00
24.01	GRANT REVENUE	2,137,345	24.01
24.02	MISCELLANEOUS INCOME	-1,338,827	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	22,438,840	25.00
26.00	Total (line 5 plus line 25)	26,148,667	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)	26,148,667	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet H

HHA CCN: 15-7155

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00	445,410	0	98	11,458	101,853	558,819	5.00
HHA REIMBURSABLE SERVICES							
6.00	687,260	0	0	0	0	687,260	6.00
7.00	344,800	0	0	0	0	344,800	7.00
8.00	238,829	0	0	0	0	238,829	8.00
9.00	14,600	0	0	0	0	14,600	9.00
10.00	0	0	0	0	0	0	10.00
11.00	45,685	0	0	0	0	45,685	11.00
12.00	0	0	0	0	7,994	7,994	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	1,776,584	0	98	11,458	109,847	1,897,987	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	558,819	-158,937	399,882			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	687,260	0	687,260			6.00
7.00	0	344,800	0	344,800			7.00
8.00	0	238,829	0	238,829			8.00
9.00	0	14,600	0	14,600			9.00
10.00	0	0	409	409			10.00
11.00	0	45,685	0	45,685			11.00
12.00	0	7,994	0	7,994			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	0	1,897,987	-158,528	1,739,459			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 5/29/2024 10:24 am

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet H-1 Part I
		HHA CCN: 15-7155	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	399,882	0	0	0	399,882	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	687,260	0	0	0	687,260	6.00
7.00	Physical Therapy	344,800	0	0	0	344,800	7.00
8.00	Occupational Therapy	238,829	0	0	0	238,829	8.00
9.00	Speech Pathology	14,600	0	0	0	14,600	9.00
10.00	Medical Social Services	409	0	0	0	409	10.00
11.00	Home Health Aide	45,685	0	0	0	45,685	11.00
12.00	Supplies (see instructions)	7,994	0	0	0	7,994	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,739,459	0	0	0	1,739,459	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				

GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	399,882					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	205,156	892,416				6.00
7.00	Physical Therapy	102,928	447,728				7.00
8.00	Occupational Therapy	71,294	310,123				8.00
9.00	Speech Pathology	4,358	18,958				9.00
10.00	Medical Social Services	122	531				10.00
11.00	Home Health Aide	13,638	59,323				11.00
12.00	Supplies (see instructions)	2,386	10,380				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		1,739,459				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet H-1

HHA CCN: 15-7155

To 12/31/2023

Part II
Date/Time Prepared:
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-399,882	1,339,577
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	687,260
7.00	Physical Therapy	0	0	0	0	0	344,800
8.00	Occupational Therapy	0	0	0	0	0	238,829
9.00	Speech Pathology	0	0	0	0	0	14,600
10.00	Medical Social Services	0	0	0	0	0	409
11.00	Home Health Aide	0	0	0	0	0	45,685
12.00	Supplies (see instructions)	0	0	0	0	0	7,994
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-399,882	1,339,577
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	399,882
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.298514

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet H-2

HHA CCN: 15-7155

To 12/31/2023

Part I
Date/Time Prepared:
5/29/2024 10:24 am

Home Health
Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	36,321	481	98,699	135,501	23,030	1.00
2.00 Skilled Nursing Care	892,416	0	0	240,710	1,133,126	192,592	2.00
3.00 Physical Therapy	447,728	0	0	120,765	568,493	96,623	3.00
4.00 Occupational Therapy	310,123	0	0	83,649	393,772	66,927	4.00
5.00 Speech Pathology	18,958	0	0	5,114	24,072	4,091	5.00
6.00 Medical Social Services	531	0	0	143	674	115	6.00
7.00 Home Health Aide	59,323	0	0	16,001	75,324	12,802	7.00
8.00 Supplies (see instructions)	10,380	0	0	0	10,380	1,764	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	1,739,459	36,321	481	565,081	2,341,342	397,944	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	34,885	0	12,017	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	34,885	0	12,017	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet H-2
		HHA CCN: 15-7155	To 12/31/2023	Part I
				Date/Time Prepared: 5/29/2024 10:24 am
			Home Health Agency I	PPS

Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE PHYSICIAN PRIVATE PRACTICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
	14.00	15.00	16.00	18.00	19.00	24.00	
1.00 Administrative and General	0	0	11,162	0	0	216,595	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	1,325,718	2.00
3.00 Physical Therapy	0	0	0	0	0	665,116	3.00
4.00 Occupational Therapy	0	0	0	0	0	460,699	4.00
5.00 Speech Pathology	0	0	0	0	0	28,163	5.00
6.00 Medical Social Services	0	0	0	0	0	789	6.00
7.00 Home Health Aide	0	0	0	0	0	88,126	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	12,144	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	0	11,162	0	0	2,797,350	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
	25.00	26.00	27.00	28.00			
1.00 Administrative and General	0	216,595					1.00
2.00 Skilled Nursing Care	0	1,325,718	111,264	1,436,982			2.00
3.00 Physical Therapy	0	665,116	55,821	720,937			3.00
4.00 Occupational Therapy	0	460,699	38,665	499,364			4.00
5.00 Speech Pathology	0	28,163	2,364	30,527			5.00
6.00 Medical Social Services	0	789	66	855			6.00
7.00 Home Health Aide	0	88,126	7,396	95,522			7.00
8.00 Supplies (see instructions)	0	12,144	1,019	13,163			8.00
9.00 Drugs	0	0	0	0			9.00
10.00 DME	0	0	0	0			10.00
11.00 Home Dialysis Aide Services	0	0	0	0			11.00
12.00 Respiratory Therapy	0	0	0	0			12.00
13.00 Private Duty Nursing	0	0	0	0			13.00
14.00 Clinic	0	0	0	0			14.00
15.00 Health Promotion Activities	0	0	0	0			15.00
16.00 Day Care Program	0	0	0	0			16.00
17.00 Home Delivered Meals Program	0	0	0	0			17.00
18.00 Homemaker Service	0	0	0	0			18.00
19.00 All Others (specify)	0	0	0	0			19.00
19.50 Telemedicine	0	0	0	0			19.50
20.00 Total (sum of lines 1-19) (2)	0	2,797,350	216,595	2,797,350			20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.083927				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0065 HHA CCN: 15-7155	Period: From 01/01/2023 To 12/31/2023	Worksheet H-2 Part II Date/Time Prepared: 5/29/2024 10:24 am
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	1,579	412	281,800	0	135,501	1,579	1.00
2.00 Skilled Nursing Care	0	0	687,260	0	1,133,126	0	2.00
3.00 Physical Therapy	0	0	344,800	0	568,493	0	3.00
4.00 Occupational Therapy	0	0	238,829	0	393,772	0	4.00
5.00 Speech Pathology	0	0	14,600	0	24,072	0	5.00
6.00 Medical Social Services	0	0	409	0	674	0	6.00
7.00 Home Health Aide	0	0	45,685	0	75,324	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	10,380	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	1,579	412	1,613,383		2,341,342	1,579	20.00
21.00 Total cost to be allocated	36,321	481	565,081		397,944	34,885	21.00
22.00 Unit cost multiplier	23.002533	1.167476	0.350246		0.169964	22.093097	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	1,579	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	1,579	0	0	0	0	20.00
21.00 Total cost to be allocated	0	12,017	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	7.610513	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet H-2 Part II Date/Time Prepared: 5/29/2024 10:24 am
	HHA CCN: 15-7155	To 12/31/2023	
		Home Health Agency I	PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			PHYSICIAN PRIVATE PRACTICE (TIME SPENT)			
	15.00	16.00	18.00	19.00		
1.00 Administrative and General	0	2,630,171	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19)	0	2,630,171	0	0		20.00
21.00 Total cost to be allocated	0	11,162	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.004244	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet H-3 Part I Date/Time Prepared: 5/29/2024 10:24 am
		HHA CCN: 15-7155		

Title XVIII			Home Health Agency I	PPS
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Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,436,982		1,436,982	3,430	418.95	1.00
2.00	Physical Therapy	3.00	720,937	0	720,937	2,914	247.40	2.00
3.00	Occupational Therapy	4.00	499,364	0	499,364	1,526	327.24	3.00
4.00	Speech Pathology	5.00	30,527	0	30,527	83	367.80	4.00
5.00	Medical Social Services	6.00	855		855	14	61.07	5.00
6.00	Home Health Aide	7.00	95,522		95,522	513	186.20	6.00
7.00	Total (sum of lines 1-6)		2,784,187	0	2,784,187	8,480		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits		
			Part A	Part B	
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles
0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	22		8.00
8.01	Skilled Nursing Care		31140	0	14		8.01
8.02	Skilled Nursing Care		99915	0	1,175		8.02
9.00	Physical Therapy		18020	0	31		9.00
9.01	Physical Therapy		31140	0	18		9.01
9.02	Physical Therapy		99915	0	958		9.02
10.00	Occupational Therapy		18020	0	9		10.00
10.01	Occupational Therapy		31140	0	2		10.01
10.02	Occupational Therapy		99915	0	501		10.02
11.00	Speech Pathology		18020	0	0		11.00
11.01	Speech Pathology		31140	0	0		11.01
11.02	Speech Pathology		99915	0	31		11.02
12.00	Medical Social Services		18020	0	0		12.00
12.01	Medical Social Services		31140	0	0		12.01
12.02	Medical Social Services		99915	0	4		12.02
13.00	Home Health Aide		18020	0	0		13.00
13.01	Home Health Aide		31140	0	0		13.01
13.02	Home Health Aide		99915	0	223		13.02
14.00	Total (sum of lines 8-13)			0	2,988		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	13,163	0	13,163	19,858	0.662856	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	
		Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,211		0	507,348	1.00
2.00	Physical Therapy	0	1,007		0	249,132	2.00
3.00	Occupational Therapy	0	512		0	167,547	3.00
4.00	Speech Pathology	0	31		0	11,402	4.00
5.00	Medical Social Services	0	4		0	244	5.00
6.00	Home Health Aide	0	223		0	41,523	6.00
7.00	Total (sum of lines 1-6)	0	2,988		0	977,196	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet H-3
				HHA CCN: 15-7155	To 12/31/2023	Part I
				Title XVIII	Home Health Agency I	Date/Time Prepared: 5/29/2024 10:24 am
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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
8.01	Skilled Nursing Care						8.01	
8.02	Skilled Nursing Care						8.02	
9.00	Physical Therapy						9.00	
9.01	Physical Therapy						9.01	
9.02	Physical Therapy						9.02	
10.00	Occupational Therapy						10.00	
10.01	Occupational Therapy						10.01	
10.02	Occupational Therapy						10.02	
11.00	Speech Pathology						11.00	
11.01	Speech Pathology						11.01	
11.02	Speech Pathology						11.02	
12.00	Medical Social Services						12.00	
12.01	Medical Social Services						12.01	
12.02	Medical Social Services						12.02	
13.00	Home Health Aide						13.00	
13.01	Home Health Aide						13.01	
13.02	Home Health Aide						13.02	
14.00	Total (sum of lines 8-13)						14.00	
		Program Covered Charges			Cost of Services			
Cost Center Description		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	15,249	0	0	10,108	0	
16.00	Cost of Drugs		0	0		0	0	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	507,348					1.00	
2.00	Physical Therapy	249,132					2.00	
3.00	Occupational Therapy	167,547					3.00	
4.00	Speech Pathology	11,402					4.00	
5.00	Medical Social Services	244					5.00	
6.00	Home Health Aide	41,523					6.00	
7.00	Total (sum of lines 1-6)	977,196					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
8.01	Skilled Nursing Care						8.01	
8.02	Skilled Nursing Care						8.02	
9.00	Physical Therapy						9.00	
9.01	Physical Therapy						9.01	
9.02	Physical Therapy						9.02	
10.00	Occupational Therapy						10.00	
10.01	Occupational Therapy						10.01	
10.02	Occupational Therapy						10.02	
11.00	Speech Pathology						11.00	
11.01	Speech Pathology						11.01	
11.02	Speech Pathology						11.02	
12.00	Medical Social Services						12.00	
12.01	Medical Social Services						12.01	
12.02	Medical Social Services						12.02	
13.00	Home Health Aide						13.00	
13.01	Home Health Aide						13.01	
13.02	Home Health Aide						13.02	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0065 HHA CCN: 15-7155	Period: From 01/01/2023 To 12/31/2023	Worksheet H-3 Part II Date/Time Prepared: 5/29/2024 10:24 am
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.453948	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.244106	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.294293	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.152599	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.637892	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065 HHA CCN: 15-7155	Period: From 01/01/2023 To 12/31/2023	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	789,108
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	18,677
13.00	Total PPS Reimbursement - LUPA Episodes		0	11,402
14.00	Total PPS Reimbursement - PEP Episodes		0	3,910
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,852
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	825,949
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	825,949
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	825,949
27.00	Allowable bad debts (from your records)			0
27.01	Adjusted reimbursable bad debts (see instructions)			0
28.00	Allowable bad debts for dual eligible (see instructions)			0
29.00	Total costs - current cost reporting period (see instructions)		0	825,949
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	825,949
31.01	Sequestration adjustment (see instructions)		0	16,519
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	809,429
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet H-5

HHA CCN: 15-7155

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		809,429	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		809,429	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		809,430	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	246	46,610	46,856	0	46,856
5.00	PLANT OPERATION & MAINTENANCE*	0	3,616	3,616	0	3,616
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	4,636	4,636	0	4,636
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	4,282	4,282
14.00	PHARMACY*	0	507	507	0	507
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	6,809	6,809	0	6,809
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	49,738	200	49,938	0	49,938
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	390,395	0	390,395	0	390,395
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	60,537	60,537
34.00	SPIRITUAL COUNSELING**	115,390	0	115,390	-64,819	50,571
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	100,198	0	100,198	0	100,198
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	94,020	94,020	0	94,020
39.00	PATIENT TRANSPORTATION**	0	9,645	9,645	0	9,645
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	3,357	3,357	0	3,357
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	6,408	6,408	0	6,408
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	655,967	175,808	831,775	0	831,775

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet 0
	Hospice CCN: 15-1529	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	32,244	79,100	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,616	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	86,693	86,693	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	4,636	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	4,282	13.00
14.00	PHARMACY*	0	507	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	6,809	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	49,938	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	390,395	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	60,537	33.00
34.00	SPIRITUAL COUNSELING**	0	50,571	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	100,198	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	94,020	38.00
39.00	PATIENT TRANSPORTATION**	0	9,645	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	3,357	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	6,408	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	118,937	950,712	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0065 Hospice CCN: 15-1529	Period: From 01/01/2023 To 12/31/2023	Worksheet 0-2 Date/Time Prepared: 5/29/2024 10:24 am
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	48,969	197	49,166	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	384,364	0	384,364	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	59,602	33.00
34.00	SPIRITUAL COUNSELING	113,607	0	113,607	-63,818	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	98,650	0	98,650	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	94,020	94,020	0	38.00
39.00	PATIENT TRANSPORTATION	0	9,496	9,496	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	3,305	3,305	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	645,590	107,018	752,608	-4,216	748,392

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED		25.00
26.00	PHYSICIAN SERVICES	49,166	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	384,364	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	59,602	33.00
34.00	SPIRITUAL COUNSELING	49,789	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	98,650	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	94,020	38.00
39.00	PATIENT TRANSPORTATION	9,496	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	3,305	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	748,392	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-3

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	235	1	236	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,843	0	1,843	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	286	33.00
34.00	SPIRITUAL COUNSELING	545	0	545	-306	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	473	0	473	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	46	46	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	16	16	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	3,096	63	3,159	-20	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	236	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	1,843	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	286	33.00
34.00	SPIRITUAL COUNSELING	239	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	473	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	46	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	16	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	3,139	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

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

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-4

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared:
5/29/2024 10:24 am

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	534	2	536	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	4,188	0	4,188	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	649	33.00
34.00	SPIRITUAL COUNSELING	1,238	0	1,238	-695	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,075	0	1,075	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	103	103	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	36	36	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	7,035	141	7,176	-46	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	536	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	4,188	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	649	33.00
34.00	SPIRITUAL COUNSELING	543	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,075	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	103	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	36	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	7,130	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-5

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

Descriptions		Hospice I			
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	36,321	36,321	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	270,286	270,286	3.00
4.00	ADMINISTRATIVE & GENERAL	79,100	213,699	292,799	4.00
5.00	PLANT OPERATION & MAINTENANCE	3,616	34,885	38,501	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	12,017	12,017	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	86,693	0	86,693	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,636	0	4,636	10.00
11.00	MEDICAL RECORDS	0	12,474	12,474	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	4,282	0	4,282	13.00
14.00	PHARMACY	507	0	507	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	6,809	0	6,809	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	748,392	0	748,392	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	3,139	0	3,139	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7,130	0	7,130	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	6,408	0	6,408	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	950,712	579,682	1,530,394	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-6

Hospice CCN: 15-1529

To 12/31/2023

Part I
Date/Time Prepared:
5/29/2024 10:24 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	36,321	36,321			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	270,286	0	0	270,286	3.00
4.00	ADMINISTRATIVE & GENERAL	292,799	6,821	0	11,250	310,870 4.00
5.00	PLANT OPERATION & MAINTENANCE	38,501	0	0	0	38,501 5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0 6.00
7.00	HOUSEKEEPING	12,017	0	0	0	12,017 7.00
8.00	DIETARY	0	0	0	0	0 8.00
9.00	NURSING ADMINISTRATION	86,693	2,247	0	30,248	119,188 9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,636	943	0	0	5,579 10.00
11.00	MEDICAL RECORDS	12,474	0	0	0	12,474 11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0 12.00
13.00	VOLUNTEER SERVICE COORDINATION	4,282	0	0	0	4,282 13.00
14.00	PHARMACY	507	0	0	0	507 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	9,823	0	0	9,823 15.00
16.00	OTHER GENERAL SERVICE	6,809	4,495	0	0	11,304 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		3,348	0		3,348 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	748,392			225,253	973,645 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	3,139	0	0	1,080	4,219 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7,130	0	0	2,455	9,585 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	8,644	0	0	8,644 60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0 61.00
62.00	FUNDRAISING	0	0	0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0 65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0 66.00
67.00	ADVERTISING	6,408	0	0	0	6,408 67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0 68.00
69.00	THRIFT STORE	0	0	0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	1,530,394	36,321	0	270,286	1,530,394 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-6

Hospice CCN: 15-1529

To 12/31/2023

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Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	310,870					4.00
5.00 PLANT OPERATION & MAINTENANCE	9,814	48,315				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	3,063	0		15,080		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	30,382	3,681		1,149		9.00
10.00 ROUTINE MEDICAL SUPPLIES	1,422	1,544		482		10.00
11.00 MEDICAL RECORDS	3,180	0		0		11.00
12.00 STAFF TRANSPORTATION	0	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	1,092	0		0		13.00
14.00 PHARMACY	129	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	2,504	16,088		5,021		15.00
16.00 OTHER GENERAL SERVICE	2,882	7,362		2,298		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	853	5,483		1,711		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	248,195					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	1,075	0	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	2,443	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	2,203	14,157		4,419		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	1,633	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	310,870	48,315	0	15,080	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

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Hospice CCN: 15-1529

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Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	154,400					9.00
10.00	0	9,027				10.00
11.00	0		15,654			11.00
12.00	0			0		12.00
13.00	0			0	5,374	13.00
14.00	0			0	0	14.00
15.00	0			0	0	15.00
16.00	0			0	5,374	16.00
17.00						17.00
LEVEL OF CARE						
50.00	0	0	0	0	0	50.00
51.00	46,320	8,887	15,412	0	0	51.00
52.00	46,320	43	74	0	0	52.00
53.00	46,320	97	168	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	15,440			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	154,400	9,027	15,654	0	5,374	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

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Hospice CCN: 15-1529

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Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	636					14.00
15.00	0	33,436				15.00
16.00	636		29,856			16.00
17.00				11,395		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	0	32,919	29,395		1,354,773	51.00
52.00	0	158	141	3,482	55,512	52.00
53.00	0	359	320	7,913	67,205	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		44,863	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		8,041	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	636	33,436	29,856	11,395	1,530,394	100.00

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

Provider CCN: 15-0065

Period: From 01/01/2023

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Hospice CCN: 15-1529

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Cost Center Descriptions		Hospice I				
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)
		1.00	2.00	3.00	4A	4.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,311				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	774,658		3.00
4.00	ADMINISTRATIVE & GENERAL	434	0	32,244	-310,870	1,219,524
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	38,501
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	0	0	0	0	12,017
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	143	0	86,693	0	119,188
10.00	ROUTINE MEDICAL SUPPLIES	60	0	0	0	5,579
11.00	MEDICAL RECORDS	0	0	0	0	12,474
12.00	STAFF TRANSPORTATION	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	4,282
14.00	PHARMACY	0	0	0	0	507
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625	0	0	0	9,823
16.00	OTHER GENERAL SERVICE	286	0	0	0	11,304
17.00	PATIENT/RESIDENTIAL CARE SERVICES	213	0	0	0	3,348
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0
51.00	HOSPICE ROUTINE HOME CARE			645,590	0	973,645
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	3,096	0	4,219
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	7,035	0	9,585
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	550	0	0	0	8,644
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	6,408
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER					
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	36,321	0	270,286		310,870
101.00	UNIT COST MULTIPLIER	15.716573	0.000000	0.348910		0.254911

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

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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,877					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1,877			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	143		143		100	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60		60		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625		625		0	15.00
16.00	OTHER GENERAL SERVICE	286		286		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	213		213		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					30	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	30	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	30	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	550		550		10	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	48,315	0	15,080	0	154,400	100.00
101.00	UNIT COST MULTIPLIER	25.740543	0.000000	8.034097	0.000000	1,544.000000	101.00

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

Provider CCN: 15-0065

Period: From 01/01/2023

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Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	11,652					10.00
11.00	MEDICAL RECORDS		11,652				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	100		13.00
14.00	PHARMACY			0	0	100	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	100	100	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	11,472	11,472	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	55	55	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	125	125	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	9,027	15,654	0	5,374	636	100.00
101.00	UNIT COST MULTIPLIER	0.774717	1.343460	0.000000	53.740000	6.360000	101.00

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

Provider CCN: 15-0065

Period: From 01/01/2023

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Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL				4.00
5.00	PLANT OPERATION & MAINTENANCE				5.00
6.00	LAUNDRY & LINEN SERVICE				6.00
7.00	HOUSEKEEPING				7.00
8.00	DIETARY				8.00
9.00	NURSING ADMINISTRATION				9.00
10.00	ROUTINE MEDICAL SUPPLIES				10.00
11.00	MEDICAL RECORDS				11.00
12.00	STAFF TRANSPORTATION				12.00
13.00	VOLUNTEER SERVICE COORDINATION				13.00
14.00	PHARMACY				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	11,652			15.00
16.00	OTHER GENERAL SERVICE		11,652		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			180	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	11,472	11,472		51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	55	55	55	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	125	125	125	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0		60.00
61.00	VOLUNTEER PROGRAM		0		61.00
62.00	FUNDRAISING		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		63.00
64.00	PALLIATIVE CARE PROGRAM		0		64.00
65.00	OTHER PHYSICIAN SERVICES		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING		0		67.00
68.00	TELEHEALTH/TELEMONITORING		0		68.00
69.00	THRIFT STORE		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER				99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	33,436	29,856	11,395	100.00
101.00	UNIT COST MULTIPLIER	2.869550	2.562307	63.305556	101.00

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

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-7

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.453948	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.244106	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.294293	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.637892	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.267935	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.152599	0	0	0	7.00
8.00	BEHAVIORAL HEALTH	93.00	3.410121	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	WOUND CARE (DIABETES CENTER)	76.00	0.431380	0	0	0	10.00
10.01	OTHER ANCILLARY CMS LINE	76.01	0.000000	0	0	0	10.01
10.02	CASE MANAGEMENT	76.02	0.000000	0	0	0	10.02
10.03	PAIN MANAGEMENT	76.03	1.022024	0	0	0	10.03
10.04	SLEEP LAB	76.04	0.201317	0	0	0	10.04
10.05	ONCOLOGY	76.05	0.326477	0	0	0	10.05
10.97	CARDIAC REHABILITATION	76.97	1.563989	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	BEHAVIORAL HEALTH	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	WOUND CARE (DIABETES CENTER)	0	0	0	0	0	10.00
10.01	OTHER ANCILLARY CMS LINE	0	0	0	0	0	10.01
10.02	CASE MANAGEMENT	0	0	0	0	0	10.02
10.03	PAIN MANAGEMENT	0	0	0	0	0	10.03
10.04	SLEEP LAB	0	0	0	0	0	10.04
10.05	ONCOLOGY	0	0	0	0	0	10.05
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet 0-8

Hospice CCN: 15-1529

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Hospice I			
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,354,773	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			11,472	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			118.09	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,086	295		9.00
10.00	Program cost (line 8 times line 9)	1,309,146	34,837		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			55,512	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			55	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,009.31	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	37	18		14.00
15.00	Program cost (line 13 times line 14)	37,344	18,168		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			67,205	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			125	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			537.64	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	125	0		19.00
20.00	Program cost (line 18 times line 19)	67,205	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,477,490	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			11,652	22.00
23.00	Average cost per diem (line 21 divided by line 22)			126.80	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/29/2024 10:24 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		283,102	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,104	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		19.85	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		292,206	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8564	To 12/31/2023	

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	735,276	0	735,276	0	735,276	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	119,056	0	119,056	0	119,056	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	102,134	0	102,134	0	102,134	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	347,541	0	347,541	0	347,541	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,304,007	0	1,304,007	0	1,304,007	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	69,497	69,497	0	69,497	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	70,999	70,999	0	70,999	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	140,496	140,496	0	140,496	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,304,007	140,496	1,444,503	0	1,444,503	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	22,367	22,367	0	22,367	29.00
30.00	Administrative Costs	93,659	5,510	99,169	0	99,169	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	93,659	27,877	121,536	0	121,536	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,397,666	168,373	1,566,039	0	1,566,039	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8564	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	735,276
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	119,056
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	102,134
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	347,541
10.00	Subtotal (sum of lines 1 through 9)	0	1,304,007
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	69,497
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	70,999
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	140,496
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,444,503
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	22,367
30.00	Administrative Costs	0	99,169
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	121,536
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,566,039

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8565	To 12/31/2023	

		RHC II		Cost			
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	110,670	0	110,670	0	110,670	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	191,498	0	191,498	0	191,498	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	85,979	0	85,979	0	85,979	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	36,123	0	36,123	0	36,123	9.00
10.00	Subtotal (sum of lines 1 through 9)	424,270	0	424,270	0	424,270	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,795	23,795	0	23,795	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	75,020	75,020	0	75,020	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	98,815	98,815	0	98,815	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	424,270	98,815	523,085	0	523,085	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	2,039	2,039	0	2,039	29.00
30.00	Administrative Costs	38,207	2,450	40,657	0	40,657	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	38,207	4,489	42,696	0	42,696	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	462,477	103,304	565,781	0	565,781	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8565	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	110,670
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	191,498
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	85,979
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	36,123
10.00	Subtotal (sum of lines 1 through 9)	0	424,270
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	23,795
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	75,020
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	98,815
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	523,085
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	2,039
30.00	Administrative Costs	0	40,657
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	42,696
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	565,781

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period:	Worksheet M-1
	Component CCN: 15-8566	From 01/01/2023 To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 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	2,027,398	0	2,027,398	0	2,027,398	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	293,937	0	293,937	0	293,937	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	70,331	0	70,331	0	70,331	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	383,684	0	383,684	0	383,684	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,775,350	0	2,775,350	0	2,775,350	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	107,120	107,120	0	107,120	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	76,680	76,680	0	76,680	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	183,800	183,800	0	183,800	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,775,350	183,800	2,959,150	0	2,959,150	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	20,394	20,394	0	20,394	29.00
30.00	Administrative Costs	96,246	15,231	111,477	-15,000	96,477	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,246	35,625	131,871	-15,000	116,871	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,871,596	219,425	3,091,021	-15,000	3,076,021	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8566	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 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	2,027,398
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	293,937
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	70,331
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	383,684
10.00	Subtotal (sum of lines 1 through 9)	0	2,775,350
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	107,120
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	76,680
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	183,800
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,959,150
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	20,394
30.00	Administrative Costs	0	96,477
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,871
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,076,021

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-1

Component CCN: 15-8568

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 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	0	0	0	98,347	98,347	1.00
2.00	Physician Assistant	0	0	0	74,102	74,102	2.00
3.00	Nurse Practitioner	0	0	0	192,818	192,818	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
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	2,812	2,812	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	368,079	368,079	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	127,564	127,564	0	127,564	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	1,877	1,877	0	1,877	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	129,441	129,441	0	129,441	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	129,441	129,441	368,079	497,520	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	11,890	11,890	0	11,890	29.00
30.00	Administrative Costs	609,707	2,808	612,515	-368,079	244,436	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	609,707	14,698	624,405	-368,079	256,326	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	609,707	144,139	753,846	0	753,846	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-0065 Component CCN: 15-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet M-1 Date/Time Prepared: 5/29/2024 10:24 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	98,347
2.00	Physician Assistant	0	74,102
3.00	Nurse Practitioner	0	192,818
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	2,812
10.00	Subtotal (sum of lines 1 through 9)	0	368,079
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	127,564
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	1,877
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	129,441
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	497,520
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	11,890
30.00	Administrative Costs	0	244,436
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	256,326
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	753,846

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-0065 Component CCN: 15-8569		Period: From 01/01/2023 To 12/31/2023		Worksheet M-1 Date/Time Prepared: 5/29/2024 10:24 am	
		RHC V		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	1,623,062	1,623,062	1.00
2.00	Physician Assistant	0	0	0	112,716	112,716	2.00
3.00	Nurse Practitioner	0	0	0	270,798	270,798	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	1,757	1,757	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	624,943	624,943	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	2,633,276	2,633,276	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	132,514	132,514	0	132,514	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	242,101	242,101	0	242,101	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	374,615	374,615	0	374,615	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	374,615	374,615	2,633,276	3,007,891	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	12,932	12,932	0	12,932	29.00
30.00	Administrative Costs	2,811,488	11,026	2,822,514	-2,653,276	169,238	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,811,488	23,958	2,835,446	-2,653,276	182,170	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,811,488	398,573	3,210,061	-20,000	3,190,061	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period:	Worksheet M-1
	Component CCN: 15-8569	From 01/01/2023 To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC V	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,623,062
2.00	Physician Assistant	0	112,716
3.00	Nurse Practitioner	0	270,798
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	1,757
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	624,943
10.00	Subtotal (sum of lines 1 through 9)	0	2,633,276
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	132,514
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	242,101
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	374,615
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,007,891
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	12,932
30.00	Administrative Costs	0	169,238
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	182,170
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,190,061

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-0065 Component CCN: 15-8575		Period: From 01/01/2023 To 12/31/2023		Worksheet M-1 Date/Time Prepared: 5/29/2024 10:24 am	
		RHC VI		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	15,418	15,418	1.00
2.00	Physician Assistant	0	0	0	52,674	52,674	2.00
3.00	Nurse Practitioner	0	0	0	5,279	5,279	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
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	51,611	51,611	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	124,982	124,982	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	17,884	17,884	0	17,884	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	6,038	6,038	0	6,038	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,922	23,922	0	23,922	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	23,922	23,922	124,982	148,904	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	9,713	9,713	0	9,713	29.00
30.00	Administrative Costs	66,679	86,542	153,221	-124,983	28,238	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	66,679	96,255	162,934	-124,983	37,951	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	66,679	120,177	186,856	-1	186,855	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8575	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC VI	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	15,418
2.00	Physician Assistant	0	52,674
3.00	Nurse Practitioner	0	5,279
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	51,611
10.00	Subtotal (sum of lines 1 through 9)	0	124,982
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	17,884
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	6,038
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	23,922
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	148,904
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	9,713
30.00	Administrative Costs	0	28,238
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	37,951
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	186,855

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-1

Component CCN: 15-8574

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		RHC VII		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	Trial Balance (col. 3 + col. 4)	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	5,504	5,504	1.00
2.00	Physician Assistant	0	0	0	973	973	2.00
3.00	Nurse Practitioner	0	0	0	22,800	22,800	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	4,618	4,618	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	9,412	9,412	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	43,307	43,307	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	8,471	8,471	0	8,471	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	4,860	4,860	0	4,860	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,331	13,331	0	13,331	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	13,331	13,331	43,307	56,638	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	2,535	2,535	0	2,535	29.00
30.00	Administrative Costs	23,517	29,351	52,868	-43,308	9,560	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,517	31,886	55,403	-43,308	12,095	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	23,517	45,217	68,734	-1	68,733	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8574	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC VII	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	5,504
2.00	Physician Assistant	0	973
3.00	Nurse Practitioner	0	22,800
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	4,618
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	9,412
10.00	Subtotal (sum of lines 1 through 9)	0	43,307
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	8,471
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	4,860
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	13,331
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	56,638
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	2,535
30.00	Administrative Costs	0	9,560
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	12,095
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	68,733

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-1

Component CCN: 15-8578

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		RHC VIII					Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	Trial Balance (col. 3 + col. 4)	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	57,504	57,504	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	42,852	42,852	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	9,196	9,196	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	38,106	38,106	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	147,658	147,658	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	7,322	7,322	0	7,322	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	9,329	9,329	0	9,329	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,651	16,651	0	16,651	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	16,651	16,651	147,658	164,309	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	35,813	35,813	0	35,813	29.00
30.00	Administrative Costs	62,751	100,513	163,264	-147,658	15,606	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,751	136,326	199,077	-147,658	51,419	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	62,751	152,977	215,728	0	215,728	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8578	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
		RHC VIII	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	57,504
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	42,852
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	9,196
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist		
7.11	Mental Health Counselor		
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	38,106
10.00	Subtotal (sum of lines 1 through 9)	0	147,658
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	7,322
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	9,329
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	16,651
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	164,309
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	35,813
30.00	Administrative Costs	0	15,606
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	51,419
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	215,728

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8564	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 am
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	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	

VISITS AND PRODUCTIVITY Positions						
1.00	Physician	1.92	6,591	4,200	8,064	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.87	2,226	2,100	1,827	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.79	8,817		9,891	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.79	8,817		9,891	8.00
9.00	Physician Services Under Agreements		0		0	9.00

					1.00	
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DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,444,503	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,444,503	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)				121,536	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,703,671	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,825,207	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,825,207	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,825,207	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,269,710	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2
		Component CCN: 15-8565		Date/Time Prepared: 5/29/2024 10:24 am
			RHC II	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.44	1,477	4,200	1,848	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.88	3,149	2,100	1,848	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.32	4,626		3,696	4,626
5.00	Visiting Nurse	0.00	0			0
6.00	Clinical Psychologist	0.00	0			0
7.00	Clinical Social Worker	0.00	0			0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0
7.03	Marriage and Family Therapist					
7.04	Mental Health Counselor					
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.32	4,626			4,626
9.00	Physician Services Under Agreements		0			0
					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)				523,085	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)				523,085	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)				42,696	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				468,375	15.00
16.00	Total overhead (sum of lines 14 and 15)				511,071	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				511,071	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				511,071	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,034,156	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8566	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 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	3.43	3,993	4,200	14,406	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.87	556	2,100	1,827	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.30	4,549		16,233	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.30	4,549		16,233	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,959,150	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,959,150	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)				116,871	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,603,298	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,720,169	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,720,169	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,720,169	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,679,319	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 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	0.19	709	4,200	798	1.00
2.00	Physician Assistant	0.52	2,195	2,100	1,092	2.00
3.00	Nurse Practitioner	1.24	5,910	2,100	2,604	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.95	8,814		4,494	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.95	8,814		8,814	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)				497,520	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)				497,520	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)				256,326	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				719,147	15.00
16.00	Total overhead (sum of lines 14 and 15)				975,473	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				975,473	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				975,473	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,472,993	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8569	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 am
			RHC V	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	5.12	15,135	4,200	21,504	1.00
2.00	Physician Assistant	0.88	2,540	2,100	1,848	2.00
3.00	Nurse Practitioner	1.76	5,283	2,100	3,696	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.76	22,958		27,048	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.76	22,958		27,048	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				3,007,891	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,007,891	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)				182,170	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,946,873	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,129,043	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,129,043	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,129,043	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,136,934	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065	Period: From 01/01/2023	Worksheet M-2
		Component CCN: 15-8575	To 12/31/2023	Date/Time Prepared: 5/29/2024 10:24 am
			RHC VI	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	0.06	257	840	50	1.00
2.00	Physician Assistant	0.22	878	420	92	2.00
3.00	Nurse Practitioner	0.02	88	420	8	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.30	1,223		150	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.30	1,223			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)				148,904	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)				148,904	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)				37,951	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				147,424	15.00
16.00	Total overhead (sum of lines 14 and 15)				185,375	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				185,375	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				185,375	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				334,279	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8574	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 am
			RHC VII	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	0.02	147	322	6	1.00
2.00	Physician Assistant	0.00	26	161	0	2.00
3.00	Nurse Practitioner	0.09	609	161	14	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.11	782		20	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.11	782			8.00
9.00	Physician Services Under Agreements		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)				56,638	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)				56,638	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)				12,095	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				58,094	15.00
16.00	Total overhead (sum of lines 14 and 15)				70,189	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				70,189	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				70,189	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				126,827	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8578	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC VIII			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	365	1,162	46	1.00
2.00	Physician Assistant	0.00	0	581	0	2.00
3.00	Nurse Practitioner	0.03	272	581	17	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.07	637		63	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
7.03	Marriage and Family Therapist					7.03
7.04	Mental Health Counselor					7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.07	637			8.00
9.00	Physician Services Under Agreements		0			9.00

						1.00
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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)					164,309 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)					164,309 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)					51,419 14.00
15.00	Parent provider overhead allocated to facility (see instructions)					80,851 15.00
16.00	Total overhead (sum of lines 14 and 15)					132,270 16.00
17.00	Allowable GME overhead (see instructions)					0 17.00
18.00	Enter the amount from line 16					132,270 18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					132,270 19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					296,579 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8564	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC I	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,269,710 1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			728,451 2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,541,259 3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,891 4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0 5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,891 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			256.93 7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	163,296	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	163,296	16.00
16.01	Total program charges (see instructions)(from contractor's records)		168,843	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		19,891	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,238	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.)		91,915	16.04
16.05	Total program cost (see instructions)	0	111,153	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,164	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		23,930	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		111,153	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,950	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		153,103	22.00
23.00	Allowable bad debts (see instructions)		869	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		565	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		782	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)		153,668	26.00
26.01	Sequestration adjustment (see instructions)		3,073	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		107,372	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)		43,223	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8565	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC II	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,034,156	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		506,263	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		527,893	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,626	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)		4,626	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		114.11	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	114.11	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	912	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	104,068	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	104,068	16.00
16.01	Total program charges (see instructions)(from contractor's records)		137,317	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,790	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,240	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.)		59,872	16.04
16.05	Total program cost (see instructions)	0	74,112	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,988	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,708	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		74,112	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,634	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		87,746	22.00
23.00	Allowable bad debts (see instructions)		308	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		200	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		225	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)		87,946	26.00
26.01	Sequestration adjustment (see instructions)		1,759	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		80,627	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)		5,560	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8566	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 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)			4,679,319 1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			68,538 2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,610,781 3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,233 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)			16,233 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			284.04 7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	236	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	29,736	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	29,736	16.00
16.01	Total program charges (see instructions)(from contractor's records)		17,126	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,844	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,938	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.)		17,762	16.04
16.05	Total program cost (see instructions)	0	22,700	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,595	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,337	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		22,700	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		22,700	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)		22,700	26.00
26.01	Sequestration adjustment (see instructions)		454	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		22,123	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)		123	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 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)		1,472,993	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		738,104	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		734,889	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,814	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)		8,814	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		83.38	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	83.38	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	579	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	48,277	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	48,277	16.00
16.01	Total program charges (see instructions)(from contractor's records)		61,593	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		30,648	16.04
16.05	Total program cost (see instructions)	0	30,648	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,967	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,325	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		30,648	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		64,616	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		95,264	22.00
23.00	Allowable bad debts (see instructions)		829	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		539	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		829	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)		95,803	26.00
26.01	Sequestration adjustment (see instructions)		1,916	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		49,130	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)		44,757	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8569	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC V	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)			5,136,934 1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,331,735 2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,805,199 3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			27,048 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)			27,048 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			140.68 7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,196	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	528,696	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	528,696	16.00
16.01	Total program charges (see instructions)(from contractor's records)		569,890	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		68,520	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		63,567	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.)		313,622	16.04
16.05	Total program cost (see instructions)	0	377,189	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		73,101	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		85,621	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		377,189	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,973	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		414,162	22.00
23.00	Allowable bad debts (see instructions)		3,732	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,426	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,103	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)		416,588	26.00
26.01	Sequestration adjustment (see instructions)		8,332	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		365,235	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)		43,021	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8575	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC VI	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)		334,279	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		198,136	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		136,143	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,223	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)		1,223	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		111.32	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	111.32	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,593	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		36,593	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)		36,593	26.00
26.01	Sequestration adjustment (see instructions)		732	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	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)		35,861	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8574	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC VII	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)		126,827	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		82,217	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		44,610	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		782	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)		782	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		57.05	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	57.05	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,012	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		13,012	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)		13,012	26.00
26.01	Sequestration adjustment (see instructions)		260	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	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)		12,752	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8578	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 10:24 am
		Title XVIII	RHC VIII	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)		296,579	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		103,306	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		193,273	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		637	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)		637	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		303.41	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	126.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		49,750	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		49,750	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)		49,750	26.00
26.01	Sequestration adjustment (see instructions)		995	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	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)		48,755	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8564

From 01/01/2023
To 12/31/2023

Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII		RHC I	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,304,007	1,304,007	1,304,007	1,304,007	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002384	0.009650	0.087455	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,109	12,584	114,042	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	20,582	121,197	50,303	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	23,691	133,781	164,345	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,444,503	1,444,503	1,444,503	1,444,503	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	1,825,207	1,825,207	1,825,207	1,825,207	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.016401	0.092614	0.113773	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	29,935	169,040	207,659	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	53,626	302,821	372,004	0	10.00	
11.00	Total number of injections/infusions (from your records)	83	336	435	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	646.10	901.25	855.18	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	0	1	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)	0	901	41,049	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)					728,451	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)					41,950	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-4

Component CCN: 15-8565

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Title XVIII		RHC II	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	424,270	424,270	424,270	424,270	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004673	0.024824	0.110464	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,983	10,532	46,867	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	19,094	147,530	30,066	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	21,077	158,062	76,933	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	523,085	523,085	523,085	523,085	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	511,071	511,071	511,071	511,071	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.040294	0.302173	0.147076	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20,593	154,432	75,166	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	41,670	312,494	152,099	0	10.00	
11.00	Total number of injections/infusions (from your records)	77	409	260	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	541.17	764.04	585.00	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	0	1	22	0	13.00	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	764	12,870	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)					506,263	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)					13,634	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-4

Component CCN: 15-8566

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,775,350	2,775,350	2,775,350	2,775,350	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.001845	0.000280	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	5,121	777	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	35,710	1,735	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	40,831	2,512	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,959,150	2,959,150	2,959,150	2,959,150	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,720,169	1,720,169	1,720,169	1,720,169	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.013798	0.000849	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	23,735	1,460	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	64,566	3,972	0	10.00
11.00	Total number of injections/infusions (from your records)	0	99	15	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	652.18	264.80	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	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)				68,538	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)				0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-4

Component CCN: 15-8568

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	368,079	368,079	368,079	368,079	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000450	0.076691	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	166	28,228	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	3,968	216,941	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,134	245,169	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	497,520	497,520	497,520	497,520	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	975,473	975,473	975,473	975,473	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.008309	0.492782	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	8,105	480,696	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	12,239	725,865	0	10.00
11.00	Total number of injections/infusions (from your records)	0	11	1,876	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	1,112.64	386.92	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	167	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	64,616	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)				738,104	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)				64,616	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period: From 01/01/2023

Worksheet M-4

Component CCN: 15-8569

To 12/31/2023

Date/Time Prepared: 5/29/2024 10:24 am

		Title XVIII		RHC V	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,633,276	2,633,276	2,633,276	2,633,276	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002788	0.014084	0.012752	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	7,342	37,087	33,580	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	66,955	492,008	142,815	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	74,297	529,095	176,395	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,007,891	3,007,891	3,007,891	3,007,891	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	2,129,043	2,129,043	2,129,043	2,129,043	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024701	0.175902	0.058644	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	52,589	374,503	124,856	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	126,886	903,598	301,251	0	10.00	
11.00	Total number of injections/infusions (from your records)	270	1,364	1,235	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	469.95	662.46	243.93	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	4	4	133	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)	1,880	2,650	32,443	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)					1,331,735	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)					36,973	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065
Component CCN: 15-8575

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

Worksheet M-4
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII		RHC VI	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	124,982	124,982	124,982	124,982	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001870	0.027778	0.081197	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	234	3,472	10,148	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,736	37,514	35,155	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,970	40,986	45,303	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	148,904	148,904	148,904	148,904	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	185,375	185,375	185,375	185,375	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013230	0.275251	0.304243	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,453	51,025	56,399	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,423	92,011	101,702	0	10.00
11.00	Total number of injections/infusions (from your records)	7	104	304	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	631.86	884.72	334.55	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	23	41	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,527	20,349	13,717	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)				198,136	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)				36,593	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065
Component CCN: 15-8574

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

Worksheet M-4
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII		RHC VII	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	43,307	43,307	43,307	43,307	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005822	0.014556	0.131732	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	252	630	5,705	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	1,984	7,214	20,931	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,236	7,844	26,636	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	56,638	56,638	56,638	56,638	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	70,189	70,189	70,189	70,189	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.039479	0.138494	0.470285	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,771	9,721	33,009	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,007	17,565	59,645	0	10.00	
11.00	Total number of injections/infusions (from your records)	8	20	181	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	625.88	878.25	329.53	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	5	6	14	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)	3,129	5,270	4,613	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)					82,217	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)					13,012	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065
Component CCN: 15-8578

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

Worksheet M-4
Date/Time Prepared:
5/29/2024 10:24 am

		Title XVIII		RHC VIII	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	147,658	147,658	147,658	147,658	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.010040	0.086346	0.036145	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,482	12,750	5,337	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	2,480	31,021	4,163	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,962	43,771	9,500	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	164,309	164,309	164,309	164,309	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	132,270	132,270	132,270	132,270	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024113	0.266394	0.057818	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,189	35,236	7,648	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	7,151	79,007	17,148	0	10.00	
11.00	Total number of injections/infusions (from your records)	10	86	36	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	715.10	918.69	476.33	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	8	36	23	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)	5,721	33,073	10,956	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)					103,306	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)					49,750	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0065 Component CCN: 15-8564	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		107,372	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)		107,372	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		43,223	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		150,595	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: 15-0065 Component CCN: 15-8565	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		80,627	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)		80,627	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		5,560	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		86,187	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: 15-0065 Component CCN: 15-8566	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		22,123	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)		22,123	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		123	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		22,246	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: 15-0065 Component CCN: 15-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC IV	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		49,130	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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)		49,130	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			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		44,757	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		93,887	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: 15-0065 Component CCN: 15-8569	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 10:24 am
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		RHC V	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		365,235	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)		365,235	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		43,021	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		408,256	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00