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: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 6:51 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 6:51 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCOTT MEMORIAL HOSPITAL (15-1334) 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	Adam Kempf		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Adam Kempf			2
3	Signatory Title	SENIOR VP & CHIEF FINANCIAL OFFIC			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	300,925	238,265	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	398,634	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		20		0	10.00
200.00	TOTAL	0	699,559	238,285	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 6:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1451 NORTH GARDNER	PO Box:			1.00
2.00	City: SCOTTSBURG	State: IN	Zip Code: 47170-	County: SCOTT	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SCOTT MEMORIAL HOSPITAL	151334	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SCOTT MEMORIAL SWING BEDS	15Z334	99915		03/21/2013	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SCOTTSBURG FAMILY PRACTICE	158523	99915		08/09/2017	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	83,447	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N		123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0616	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: NORTON HEALTHCARE INC	Contractor's Name: CGS	Contractor's Number: 15101	141.00
142.00	Street: 234 E GRAY ST SUITE 225	PO Box:		142.00
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202	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

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						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	Y	Y	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 6:51 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/16/2024	Y	04/16/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 6:51 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	12/31/2022	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA		GERBER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3524		LGERBER@BLUEANDCO.COM		43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2024 6:51 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	19,536.00	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)		21	7,665	19,536.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	17,976.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	37,512.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 6:51 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	334	14	814			1.00
2.00	HMO and other (see instructions)	273	259				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	420	0	893			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	194			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	754	14	1,901			7.00
8.00	INTENSIVE CARE UNIT	5	1	749			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	759	15	2,650	0.00	163.11	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	419	156	2,084	0.00	5.08	26.00
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	168.19	27.00
28.00	Observation Bed Days		30	431			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 6:51 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	141	6	317	1.00
2.00	HMO and other (see instructions)			91	54		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	141	6	317	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 6:51 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1465 NORTH GARDNER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
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	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	17:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N	0	13.01
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 6:51 am
		RHC I	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 6:51 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.273524	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,267,314	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	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	1,725,286	6.00
7.00	Medicaid cost (line 1 times line 6)	471,907	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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)	0	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	925,000	26.00
27.00	Medicare reimbursable bad debts (see instructions)	104,940	27.00
27.01	Medicare allowable bad debts (see instructions)	161,446	27.01
28.00	Non-Medicare bad debt amount (see instructions)	763,554	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	265,356	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	265,356	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	265,356	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 6:51 am

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		233,074	233,074	202,605	435,679	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		364,890	364,890	118,729	483,619	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	82,083	763,163	845,246	-13,410	831,836	4.00
5.01	00550	DATA PROCESSING	193,725	1,063,051	1,256,776	0	1,256,776	5.01
5.02	00570	ADMITTING	515,298	156,591	671,889	-5,008	666,881	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	59,370	59,370	0	59,370	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	240	336,912	337,152	0	337,152	5.04
5.05	00590	OTHER ADMIN AND GENERAL	774,908	3,146,926	3,921,834	-201,388	3,720,446	5.05
7.00	00700	OPERATION OF PLANT	227,616	682,218	909,834	-4,407	905,427	7.00
9.00	00900	HOUSEKEEPING	271,323	143,177	414,500	0	414,500	9.00
10.00	01000	DIETARY	204,424	182,648	387,072	-267,549	119,523	10.00
11.00	01100	CAFETERIA	0	0	0	266,973	266,973	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	53,759	53,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,429	34,181	102,610	-31,687	70,923	14.00
15.00	01500	PHARMACY	206,130	523,313	729,443	-363,230	366,213	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	434,170	204,756	638,926	-5,755	633,171	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,326,812	1,081,227	2,408,039	-12,331	2,395,708	30.00
31.00	03100	INTENSIVE CARE UNIT	4,792	1,207	5,999	0	5,999	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,565	716,903	848,468	-75,273	773,195	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	948,518	884,862	1,833,380	-37,566	1,795,814	54.00
60.00	06000	LABORATORY	664,380	705,274	1,369,654	6,659	1,376,313	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	32,450	32,450	0	32,450	63.00
65.00	06500	RESPIRATORY THERAPY	524,956	135,396	660,352	-251,762	408,590	65.00
66.00	06600	PHYSICAL THERAPY	76,560	742,676	819,236	-2,369	816,867	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	203,725	203,725	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	134,666	134,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,346	11,346	4,440	15,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	332,849	332,849	73.00
76.00	03610	SLEEP LAB	0	1,159	1,159	0	1,159	76.00
76.97	07697	CARDIAC REHABILITATION	117,591	15,514	133,105	0	133,105	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	RURAL HEALTH CLINIC	340,753	248,298	589,051	-51,863	537,188	88.00
91.00	09100	EMERGENCY	1,264,514	1,223,043	2,487,557	1,012	2,488,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		116,218	116,218	-1,819	114,399	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,378,787	13,809,843	22,188,630	0	22,188,630	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	32,019	27,750	59,769	0	59,769	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	148,818	62,180	210,998	0	210,998	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	42,738	124,605	167,343	0	167,343	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	8,602,362	14,024,378	22,626,740	0	22,626,740	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-114,562	321,117		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	166,632	650,251		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	831,836		4.00
5.01	00550	DATA PROCESSING	0	1,256,776		5.01
5.02	00570	ADMITTING	0	666,881		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	59,370		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	337,152		5.04
5.05	00590	OTHER ADMIN AND GENERAL	-1,724,703	1,995,743		5.05
7.00	00700	OPERATION OF PLANT	0	905,427		7.00
9.00	00900	HOUSEKEEPING	0	414,500		9.00
10.00	01000	DIETARY	0	119,523		10.00
11.00	01100	CAFETERIA	-76,154	190,819		11.00
13.00	01300	NURSING ADMINISTRATION	0	53,759		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-7,100	63,823		14.00
15.00	01500	PHARMACY	0	366,213		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3	633,168		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-321,476	2,074,232		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,999		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-256,050	517,145		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-257,188	1,538,626		54.00
60.00	06000	LABORATORY	-24,700	1,351,613		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	32,450		63.00
65.00	06500	RESPIRATORY THERAPY	-4,860	403,730		65.00
66.00	06600	PHYSICAL THERAPY	-6,992	809,875		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	203,725		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	134,666		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,786		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	332,849		73.00
76.00	03610	SLEEP LAB	0	1,159		76.00
76.97	07697	CARDIAC REHABILITATION	0	133,105		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	RURAL HEALTH CLINIC	0	537,188		88.00
91.00	09100	EMERGENCY	74	2,488,643		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-114,399	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,741,481	19,447,149		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	59,769		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	-3,009	207,989		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	0		194.00
194.01	07951	MEDICAL SPECIALTY	0	167,343		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	0		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	0		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,744,490	19,882,250		200.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 6:51 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,632		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	118,562		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
	0		0	169,194		
	B - CNO					
1.00	NURSING ADMINISTRATION	13.00	39,085	3,584		1.00
	0		39,085	3,584		
	C - CORPORATE PAID BENEFITS					
1.00	NURSING ADMINISTRATION	13.00	0	11,090		1.00
	0		0	11,090		
	D - GENERAL LIABLILITY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	38,870		1.00
	0		0	38,870		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	140,996	125,977		1.00
	0		140,996	125,977		
	G - EKG RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	161,954	41,771		1.00
	0		161,954	41,771		
	H - MED SUPPLIES DRUGS COGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	134,666		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	838		2.00
3.00	LABORATORY	60.00	0	7,609		3.00
4.00	EMERGENCY	91.00	0	3,929		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	147,042		
	I - COST TO CHARGE					
1.00	OPERATING ROOM	50.00	0	0		1.00
2.00	LABORATORY	60.00	0	0		2.00
3.00	BLOOD STORING PROCESSING & TRANS.	63.00	0	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	0		4.00
5.00	SPEECH PATHOLOGY	68.00	0	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	0		6.00
7.00	EMERGENCY	91.00	0	0		7.00
	0		0	0		
	J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	150,154		1.00
2.00		0.00	0	0		2.00
	0		0	150,154		
	L - IMPLANTS RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,440		1.00
2.00		0.00	0	0		2.00
	0		0	4,440		
	M - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	332,849		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	31		2.00
	0		0	332,880		
	O - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,819		1.00
	0		0	1,819		
500.00	Grand Total: Increases		342,035	1,026,821		500.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 6:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,320	10		1.00
2.00	ADMITTING	5.02	0	5,008	10		2.00
3.00	OTHER ADMIN AND GENERAL	5.05	0	8,398	0		3.00
4.00	OPERATION OF PLANT	7.00	0	4,407	0		4.00
5.00	DIETARY	10.00	0	576	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	534	0		6.00
7.00	PHARMACY	15.00	0	506	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,755	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	13,169	0		9.00
10.00	OPERATING ROOM	50.00	0	50,397	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,150	0		11.00
12.00	LABORATORY	60.00	0	950	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	18,663	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,581	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	51,863	0		15.00
16.00	EMERGENCY	91.00	0	2,917	0		16.00
	0		0	169,194			
	B - CNO						
1.00	OTHER ADMIN AND GENERAL	5.05	39,085	3,584	0		1.00
	0		39,085	3,584			
	C - CORPORATE PAID BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,090	0		1.00
	0		0	11,090			
	D - GENERAL LIABLILITY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.05	0	38,870	12		1.00
	0		0	38,870			
	E - CAFETERIA						
1.00	DIETARY	10.00	140,996	125,977	0		1.00
	0		140,996	125,977			
	G - EKG RECLASS						
1.00	RESPIRATORY THERAPY	65.00	161,954	41,771	0		1.00
	0		161,954	41,771			
	H - MED SUPPLIES DRUGS COGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,373	0		1.00
2.00	PHARMACY	15.00	0	29,844	0		2.00
3.00	OPERATING ROOM	50.00	0	21,247	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,416	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	29,374	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	788	0		6.00
	0		0	147,042			
	I - COST TO CHARGE						
1.00	ADULTS & PEDIATRICS	30.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	0	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	0	0		5.00
6.00	EMERGENCY	91.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	0			
	J - PROPERTY TAX						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	38,703	13		1.00
2.00	OTHER ADMIN AND GENERAL	5.05	0	111,451	0		2.00
	0		0	150,154			
	L - IMPLANTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	811	0		1.00
2.00	OPERATING ROOM	50.00	0	3,629	0		2.00
	0		0	4,440			
	M - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	332,880	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	332,880			
	O - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,819	11		1.00
	0		0	1,819			
500.00	Grand Total: Decreases		342,035	1,026,821			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	840,000	0	0	0	412,000	1.00
2.00	Land Improvements	444,683	0	0	0	406,919	2.00
3.00	Buildings and Fixtures	3,056,164	0	0	0	517,551	3.00
4.00	Building Improvements	662,251	0	0	0	662,251	4.00
5.00	Fixed Equipment	2,171,592	0	0	0	1,707,455	5.00
6.00	Movable Equipment	4,639,758	0	0	0	3,999,452	6.00
7.00	HIT designated Assets	1,345,381	0	0	0	1,345,381	7.00
8.00	Subtotal (sum of lines 1-7)	13,159,829	0	0	0	9,051,009	8.00
9.00	Reconciling Items	0	87,693	0	87,693	0	9.00
10.00	Total (line 8 minus line 9)	13,159,829	-87,693	0	-87,693	9,051,009	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	428,000	0	1.00
2.00	Land Improvements	37,764	0	2.00
3.00	Buildings and Fixtures	2,538,613	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	464,137	0	5.00
6.00	Movable Equipment	640,306	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,108,820	0	8.00
9.00	Reconciling Items	87,693	0	9.00
10.00	Total (line 8 minus line 9)	4,021,127	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2024 6:51 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	233,074	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	364,890	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	597,964	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	233,074		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	364,890		2.00
3.00	Total (sum of lines 1-2)	0	597,964		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/31/2024 6:51 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,468,514	0	3,468,514	0.844163	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	640,306	0	640,306	0.155837	0	2.00
3.00	Total (sum of lines 1-2)	4,108,820	0	4,108,820	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	118,766	50,632	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	531,522	118,562	2.00
3.00	Total (sum of lines 1-2)	0	0	0	650,288	169,194	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	1,565	0	150,154	0	321,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	38,870	-38,703	0	650,251	2.00
3.00	Total (sum of lines 1-2)	1,565	38,870	111,451	0	971,368	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 6:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-254	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-864,313			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	121,958			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,154	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-322	OTHER ADMIN AND GENERAL	5.05	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	-6,992	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	A	-125,096	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	137,076	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 6:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	ADVERTISING	A	-38,335	OTHER ADMIN AND GENERAL	5.05	0	33.00
33.01	LEGAL FEES	A	-63,750	OTHER ADMIN AND GENERAL	5.05	0	33.01
33.03	MISC EXP	A	-11,250	OTHER ADMIN AND GENERAL	5.05	9	33.03
34.00	PHYSICIAN RECRUITING	A	-81,153	OTHER ADMIN AND GENERAL	5.05	0	34.00
34.01	LOST CHARGES	A	39	ADULTS & PEDIATRICS	30.00	0	34.01
36.00	LOST CHARGES	A	74	EMERGENCY	91.00	0	36.00
37.00	INDIANA PROVIDER TAX	A	-1,606,055	OTHER ADMIN AND GENERAL	5.05	0	37.00
37.01	RENTAL INCOME	B	-116,585	OTHER ADMIN AND GENERAL	5.05	0	37.01
37.02	MISC INCOME - OTHER ADMIN AND GENERA	B	-10,547	OTHER ADMIN AND GENERAL	5.05	0	37.02
37.03	MISC INCOME - CENTRAL SERVICES & SUP	B	-51	CENTRAL SERVICES & SUPPLY	14.00	0	37.03
37.04	LOBBYING DUES OFFSET	A	-2,777	OTHER ADMIN AND GENERAL	5.05	0	37.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,744,490				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2024 6:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	113.00	INTEREST EXPENSE	HOME OFFICE INTEREST	0	114,399	1.00
2.00	5.05	OTHER ADMIN AND GENERAL	HOME OFFICE MANAGEMENT	534,272	442,276	2.00
3.00	5.05	OTHER ADMIN AND GENERAL	C SUITE PAYROLL TAXES	-9,158	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	HPG PURCHASING	7,338	14,387	4.00
4.01	5.05	OTHER ADMIN AND GENERAL	MALPRACTICE	20,815	76,858	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL EXPENSE	10,788	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL EXPENSE	29,556	0	4.03
4.04	5.05	OTHER ADMIN AND GENERAL	NON-CAPITAL EXPENSE	322,891	0	4.04
4.05	5.05	OTHER ADMIN AND GENERAL	NORTON SYSTEM FEE ALLOCATION	0	143,615	4.05
4.06	192.00	PHYSICIANS PRIVATE OFFICES	NORTON SYSTEM FEE ALLOCATION	0	3,009	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			916,502	794,544	5.00

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

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

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

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

6.00	B		0.00	LIFEPOINT HOSP	100.00	6.00
7.00			0.00	HPG	0.00	7.00
8.00	B		0.00	NORTON HEALTHCA	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2024 6:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-114,399	0		1.00
2.00	91,996	0		2.00
3.00	-9,158	0		3.00
4.00	-7,049	0		4.00
4.01	-56,043	0		4.01
4.02	10,788	9		4.02
4.03	29,556	9		4.03
4.04	322,891	0		4.04
4.05	-143,615	0		4.05
4.06	-3,009	0		4.06
5.00	121,958			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00	HOME OFFICE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 6:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	321,515	321,515	0	0	0	1.00
2.00	50.00	OPERATING ROOM	313,164	256,050	57,114	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	257,188	257,188	0	0	0	3.00
4.00	60.00	LABORATORY	24,700	24,700	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	4,860	4,860	0	0	0	5.00
6.00	91.00	EMERGENCY	618,082	0	618,082	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,539,509	864,313	675,196		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	321,515		1.00
2.00	50.00	OPERATING ROOM	0	0	0	256,050		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	257,188		3.00
4.00	60.00	LABORATORY	0	0	0	24,700		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	4,860		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	864,313		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2024 6:51 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.55	7.00
8.00	Optional travel expense rate per mile					0.66	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,254.00	0.00	9,998.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	97.62	0.00	48.81	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	48.81	48.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					220,035	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					220,035	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					488,002	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					708,037	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					708,037	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 6:51 am

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	97.62	0.00	48.81	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	708,037		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	708,037		63.00
64.00	Total cost of outside supplier services (from your records)	715,029		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	6,992		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	321,117	321,117				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	650,251		650,251			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	831,836	0	0	831,836		4.00
5.01	00550	DATA PROCESSING	1,256,776	1,983	4,964	18,913	1,282,636	5.01
5.02	00570	ADMITTING	666,881	9,046	22,640	50,309	95,829	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	59,370	5,389	13,486	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	337,152	1,751	4,382	23	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	1,995,743	41,863	104,769	71,838	103,201	5.05
7.00	00700	OPERATION OF PLANT	905,427	10,639	26,625	22,222	29,486	7.00
9.00	00900	HOUSEKEEPING	414,500	2,226	5,570	26,489	7,371	9.00
10.00	01000	DIETARY	119,523	6,427	16,085	6,192	22,114	10.00
11.00	01100	CAFETERIA	190,819	3,279	8,207	13,765	0	11.00
13.00	01300	NURSING ADMINISTRATION	53,759	0	0	3,816	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,823	0	0	6,681	51,600	14.00
15.00	01500	PHARMACY	366,213	0	0	20,124	66,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	633,168	4,256	10,651	42,388	81,086	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,074,232	37,164	93,010	129,538	140,059	30.00
31.00	03100	INTENSIVE CARE UNIT	5,999	1,964	4,914	468	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,145	52,802	132,142	12,845	117,944	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,538,626	13,945	34,900	92,604	125,315	54.00
60.00	06000	LABORATORY	1,351,613	6,064	15,176	64,863	66,343	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	32,450	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	403,730	8,396	21,012	35,440	0	65.00
66.00	06600	PHYSICAL THERAPY	809,875	8,527	21,340	7,475	66,343	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	203,725	0	0	15,812	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	134,666	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,786	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,849	1,674	4,190	0	0	73.00
76.00	03610	SLEEP LAB	1,159	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	133,105	2,871	7,186	11,480	73,715	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	RURAL HEALTH CLINIC	537,188	8,903	22,281	33,268	110,572	88.00
91.00	09100	EMERGENCY	2,488,643	17,816	44,586	123,455	103,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,447,149	246,985	618,116	810,008	1,260,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,669	4,178	0	0	190.00
190.01	19001	MARKETING	59,769	0	0	3,126	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	207,989	0	0	14,529	22,114	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	5,579	13,963	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	167,343	5,591	13,994	4,173	0	194.01
194.02	07952	MEDICAL OFFICE	0	36,563	0	0	0	194.02
194.03	07953	VA PROPERTY	0	24,730	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	19,882,250	321,117	650,251	831,836	1,282,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING	844,705					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	78,245				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	343,308			5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	446	0	2,317,860	2,317,860	5.05
7.00	00700	OPERATION OF PLANT	0	999	0	995,398	131,357	7.00
9.00	00900	HOUSEKEEPING	0	2,373	0	458,529	60,509	9.00
10.00	01000	DIETARY	0	5,196	0	175,537	23,165	10.00
11.00	01100	CAFETERIA	0	0	0	216,070	28,513	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	57,575	7,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	122,104	16,113	14.00
15.00	01500	PHARMACY	0	695	0	453,375	59,829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	89	0	771,638	101,828	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,866	4,155	5,981	2,618,005	345,482	30.00
31.00	03100	INTENSIVE CARE UNIT	2,995	0	134	16,474	2,174	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,812	2,111	3,569	844,370	111,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,258	1,773	85,928	1,946,349	256,848	54.00
60.00	06000	LABORATORY	151,088	20,975	89,853	1,765,975	233,045	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	5,450	1,653	1,348	40,901	5,397	63.00
65.00	06500	RESPIRATORY THERAPY	72,295	1,082	16,299	558,254	73,669	65.00
66.00	06600	PHYSICAL THERAPY	72,001	461	19,673	1,005,695	132,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,350	0	3,593	41,943	5,535	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,951	0	7,272	238,760	31,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	103,607	6,252	5,416	249,941	32,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	804	52	16,642	2,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,840	18,572	26,301	521,426	68,809	73.00
76.00	03610	SLEEP LAB	0	3	407	1,569	207	76.00
76.97	07697	CARDIAC REHABILITATION	0	71	2,939	231,367	30,532	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	RURAL HEALTH CLINIC	0	2,071	2,383	716,666	94,574	88.00
91.00	09100	EMERGENCY	56,192	8,360	72,160	2,914,413	384,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	844,705	78,141	343,308	19,296,836	2,240,606	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	5,847	772	190.00
190.01	19001	MARKETING	0	0	0	62,895	8,300	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	244,632	32,283	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	19,542	2,579	194.00
194.01	07951	MEDICAL SPECIALTY	0	104	0	191,205	25,232	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	36,563	4,825	194.02
194.03	07953	VA PROPERTY	0	0	0	24,730	3,263	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	844,705	78,245	343,308	19,882,250	2,317,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,126,755					7.00
9.00	00900	HOUSEKEEPING	10,013	529,051				9.00
10.00	01000	DIETARY	28,917	0	227,619			10.00
11.00	01100	CAFETERIA	14,753	6,796	0	266,132		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,253	68,426	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	4,185	0	14.00
15.00	01500	PHARMACY	0	0	0	7,010	1,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,148	14,308	0	18,271	14,606	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	167,202	138,076	206,953	63,149	18,357	30.00
31.00	03100	INTENSIVE CARE UNIT	8,834	20,032	1,846	1,662	1,382	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237,552	100,158	0	10,069	10,757	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,740	24,324	0	32,296	0	54.00
60.00	06000	LABORATORY	27,281	40,063	0	33,435	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	1,805	0	63.00
65.00	06500	RESPIRATORY THERAPY	37,773	20,032	0	16,638	1,349	65.00
66.00	06600	PHYSICAL THERAPY	38,363	28,617	0	16,346	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,823	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,447	0	4,672	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,532	7,154	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	688	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,917	7,154	0	2,926	1,645	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	RURAL HEALTH CLINIC	40,054	0	0	0	0	88.00
91.00	09100	EMERGENCY	80,152	110,890	18,820	44,981	18,685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	793,231	529,051	227,619	265,209	68,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7,510	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	923	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	25,100	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	25,156	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	164,498	0	0	0	0	194.02
194.03	07953	VA PROPERTY	111,260	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,126,755	529,051	227,619	266,132	68,426	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
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	142,402					14.00
15.00	01500	PHARMACY	1,430	523,289				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184	0	939,983			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,546	0	16,377	3,582,147	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	366	52,770	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,343	0	9,773	1,328,448	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,647	0	235,286	2,561,490	0	54.00
60.00	06000	LABORATORY	43,142	0	245,977	2,388,918	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,400	0	3,691	55,194	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,225	0	44,629	754,569	0	65.00
66.00	06600	PHYSICAL THERAPY	949	0	53,870	1,276,556	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,838	61,139	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	19,911	306,298	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,859	0	14,831	310,614	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,654	0	141	20,633	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,201	523,289	72,017	1,238,428	0	73.00
76.00	03610	SLEEP LAB	6	0	1,115	3,585	0	76.00
76.97	07697	CARDIAC REHABILITATION	147	0	8,047	294,735	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	RURAL HEALTH CLINIC	4,259	0	6,526	862,079	0	88.00
91.00	09100	EMERGENCY	17,196	0	197,588	3,787,318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142,188	523,289	939,983	18,884,921	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	14,129	0	190.00
190.01	19001	MARKETING	0	0	0	72,118	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	276,915	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	47,221	0	194.00
194.01	07951	MEDICAL SPECIALTY	214	0	0	241,807	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	205,886	0	194.02
194.03	07953	VA PROPERTY	0	0	0	139,253	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	142,402	523,289	939,983	19,882,250	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Total		
			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
5.01	00550	DATA PROCESSING			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,582,147		30.00
31.00	03100	INTENSIVE CARE UNIT	52,770		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,328,448		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,561,490		54.00
60.00	06000	LABORATORY	2,388,918		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	55,194		63.00
65.00	06500	RESPIRATORY THERAPY	754,569		65.00
66.00	06600	PHYSICAL THERAPY	1,276,556		66.00
67.00	06700	OCCUPATIONAL THERAPY	61,139		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	306,298		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,614		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,633		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,238,428		73.00
76.00	03610	SLEEP LAB	3,585		76.00
76.97	07697	CARDIAC REHABILITATION	294,735		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	862,079		88.00
91.00	09100	EMERGENCY	3,787,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,884,921		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	14,129		190.00
190.01	19001	MARKETING	72,118		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	276,915		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	47,221		194.00
194.01	07951	MEDICAL SPECIALTY	241,807		194.01
194.02	07952	MEDICAL OFFICE	205,886		194.02
194.03	07953	VA PROPERTY	139,253		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	0		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,882,250		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	DATA PROCESSING	0	1,983	4,964	6,947	0	5.01
5.02	00570	ADMITTING	0	9,046	22,640	31,686	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	5,389	13,486	18,875	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,751	4,382	6,133	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	62,104	41,863	104,769	208,736	0	5.05
7.00	00700	OPERATION OF PLANT	0	10,639	26,625	37,264	0	7.00
9.00	00900	HOUSEKEEPING	0	2,226	5,570	7,796	0	9.00
10.00	01000	DIETARY	0	6,427	16,085	22,512	0	10.00
11.00	01100	CAFETERIA	0	3,279	8,207	11,486	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,256	10,651	14,907	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	37,164	93,010	130,174	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,964	4,914	6,878	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,802	132,142	184,944	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,945	34,900	48,845	0	54.00
60.00	06000	LABORATORY	0	6,064	15,176	21,240	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,396	21,012	29,408	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,527	21,340	29,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,674	4,190	5,864	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,871	7,186	10,057	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	RURAL HEALTH CLINIC	0	8,903	22,281	31,184	0	88.00
91.00	09100	EMERGENCY	0	17,816	44,586	62,402	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,104	246,985	618,116	927,205	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,669	4,178	5,847	0	190.00
190.01	19001	MARKETING	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	5,579	13,963	19,542	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	5,591	13,994	19,585	0	194.01
194.02	07952	MEDICAL OFFICE	0	36,563	0	36,563	0	194.02
194.03	07953	VA PROPERTY	0	24,730	0	24,730	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	62,104	321,117	650,251	1,033,472	0	202.00

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		Cost Center Description	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00550	DATA PROCESSING	6,947					5.01
5.02	00570	ADMITTING	519	32,205				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	18,875			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	6,133		5.04
5.05	00590	OTHER ADMIN AND GENERAL	559	0	108	0	209,403	5.05
7.00	00700	OPERATION OF PLANT	160	0	241	0	11,867	7.00
9.00	00900	HOUSEKEEPING	40	0	572	0	5,467	9.00
10.00	01000	DIETARY	120	0	1,253	0	2,093	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,576	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	686	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	279	0	0	0	1,456	14.00
15.00	01500	PHARMACY	359	0	168	0	5,405	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	439	0	22	0	9,199	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	759	5,103	1,002	107	31,212	30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0	2	196	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	639	222	509	64	10,067	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679	2,030	428	1,531	23,204	54.00
60.00	06000	LABORATORY	359	5,762	5,060	1,619	21,054	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	208	399	24	488	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,756	261	290	6,656	65.00
66.00	06600	PHYSICAL THERAPY	359	2,745	111	350	11,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,462	0	64	500	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	456	0	130	2,846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,950	1,508	96	2,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	194	1	198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,255	4,480	469	6,216	73.00
76.00	03610	SLEEP LAB	0	0	1	7	19	76.00
76.97	07697	CARDIAC REHABILITATION	399	0	17	52	2,758	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	RURAL HEALTH CLINIC	599	0	499	42	8,544	88.00
91.00	09100	EMERGENCY	559	2,142	2,017	1,285	34,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,827	32,205	18,850	6,133	202,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	70	190.00
190.01	19001	MARKETING	0	0	0	0	750	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	120	0	0	0	2,917	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	233	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	25	0	2,280	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	436	194.02
194.03	07953	VA PROPERTY	0	0	0	0	295	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,947	32,205	18,875	6,133	209,403	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	49,532					7.00
9.00	00900	HOUSEKEEPING	440	14,315				9.00
10.00	01000	DIETARY	1,271	0	27,249			10.00
11.00	01100	CAFETERIA	649	184	0	14,895		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	182	868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	234	0	14.00
15.00	01500	PHARMACY	0	0	0	392	21	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	842	387	0	1,023	185	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,350	3,736	24,775	3,532	233	30.00
31.00	03100	INTENSIVE CARE UNIT	388	542	221	93	18	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,445	2,710	0	564	136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,758	658	0	1,808	0	54.00
60.00	06000	LABORATORY	1,199	1,084	0	1,871	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	101	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,660	542	0	931	17	65.00
66.00	06600	PHYSICAL THERAPY	1,686	774	0	915	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	214	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	310	0	262	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	331	194	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	39	0	76.00
76.97	07697	CARDIAC REHABILITATION	568	194	0	164	21	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	RURAL HEALTH CLINIC	1,761	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,523	3,000	2,253	2,518	237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,871	14,315	27,249	14,843	868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	330	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	52	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	1,103	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	1,106	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	7,231	0	0	0	0	194.02
194.03	07953	VA PROPERTY	4,891	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,532	14,315	27,249	14,895	868	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
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	1,969					14.00
15.00	01500	PHARMACY	20	6,365				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3	0	27,007			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	118	0	470	208,571	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	11	8,463	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60	0	281	210,641	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50	0	6,759	88,750	0	54.00
60.00	06000	LABORATORY	596	0	7,070	66,914	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	47	0	106	1,373	0	63.00
65.00	06500	RESPIRATORY THERAPY	31	0	1,282	43,834	0	65.00
66.00	06600	PHYSICAL THERAPY	13	0	1,548	50,358	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	283	2,523	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	572	4,576	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178	0	426	9,138	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23	0	4	420	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	528	6,365	2,069	31,771	0	73.00
76.00	03610	SLEEP LAB	0	0	32	98	0	76.00
76.97	07697	CARDIAC REHABILITATION	2	0	231	14,463	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	RURAL HEALTH CLINIC	59	0	187	42,875	0	88.00
91.00	09100	EMERGENCY	238	0	5,676	120,595	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,966	6,365	27,007	905,363	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	6,247	0	190.00
190.01	19001	MARKETING	0	0	0	802	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	3,037	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	20,878	0	194.00
194.01	07951	MEDICAL SPECIALTY	3	0	0	22,999	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	44,230	0	194.02
194.03	07953	VA PROPERTY	0	0	0	29,916	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,969	6,365	27,007	1,033,472	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	Total		
			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
5.01	00550	DATA PROCESSING			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	208,571		30.00
31.00	03100	INTENSIVE CARE UNIT	8,463		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	210,641		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,750		54.00
60.00	06000	LABORATORY	66,914		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,373		63.00
65.00	06500	RESPIRATORY THERAPY	43,834		65.00
66.00	06600	PHYSICAL THERAPY	50,358		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,523		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,576		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,138		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	420		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,771		73.00
76.00	03610	SLEEP LAB	98		76.00
76.97	07697	CARDIAC REHABILITATION	14,463		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	42,875		88.00
91.00	09100	EMERGENCY	120,595		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	905,363		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	6,247		190.00
190.01	19001	MARKETING	802		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,037		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	20,878		194.00
194.01	07951	MEDICAL SPECIALTY	22,999		194.01
194.02	07952	MEDICAL OFFICE	44,230		194.02
194.03	07953	VA PROPERTY	29,916		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	0		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,033,472		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF COMPU TERS)	ADMITTING (INPATIENT CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,849					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		105,064				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,520,279			4.00
5.01	00550	DATA PROCESSING	802	802	193,725	174		5.01
5.02	00570	ADMITTING	3,658	3,658	515,298	13	7,553,921	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,179	2,179	0	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	708	708	240	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	16,928	16,928	735,823	14	0	5.05
7.00	00700	OPERATION OF PLANT	4,302	4,302	227,616	4	0	7.00
9.00	00900	HOUSEKEEPING	900	900	271,323	1	0	9.00
10.00	01000	DIETARY	2,599	2,599	63,428	3	0	10.00
11.00	01100	CAFETERIA	1,326	1,326	140,996	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	39,085	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	68,429	7	0	14.00
15.00	01500	PHARMACY	0	0	206,130	9	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,721	1,721	434,170	11	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,028	15,028	1,326,812	19	1,197,128	30.00
31.00	03100	INTENSIVE CARE UNIT	794	794	4,792	0	26,779	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,351	21,351	131,565	16	51,976	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,639	5,639	948,518	17	476,273	54.00
60.00	06000	LABORATORY	2,452	2,452	664,380	9	1,351,107	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	48,739	63.00
65.00	06500	RESPIRATORY THERAPY	3,395	3,395	363,002	0	646,509	65.00
66.00	06600	PHYSICAL THERAPY	3,448	3,448	76,560	9	643,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	342,949	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	161,954	0	106,871	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	926,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677	677	0	0	1,232,665	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,161	1,161	117,591	10	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	RURAL HEALTH CLINIC	3,600	3,600	340,753	15	0	88.00
91.00	09100	EMERGENCY	7,204	7,204	1,264,514	14	502,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,872	99,872	8,296,704	171	7,553,921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	675	675	0	0	0	190.00
190.01	19001	MARKETING	0	0	32,019	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	148,818	3	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	2,256	2,256	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	2,261	2,261	42,738	0	0	194.01
194.02	07952	MEDICAL OFFICE	14,785	0	0	0	0	194.02
194.03	07953	VA PROPERTY	10,000	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	321,117	650,251	831,836	1,282,636	844,705	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.473003	6.189094	0.097630	7,371.471264	0.111823	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF COMPU TERS)	ADMITTING (INPATIENT CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			0	6,947	32,205	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	39.925287	0.004263	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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,536,085					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	68,712,604				5.04
5.05	00590	OTHER ADMIN AND GENERAL	8,753	0	-2,317,860	17,564,390		5.05
7.00	00700	OPERATION OF PLANT	19,613	0	0	995,398	101,272	7.00
9.00	00900	HOUSEKEEPING	46,581	0	0	458,529	900	9.00
10.00	01000	DIETARY	102,003	0	0	175,537	2,599	10.00
11.00	01100	CAFETERIA	0	0	0	216,070	1,326	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	57,575	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	122,104	0	14.00
15.00	01500	PHARMACY	13,648	0	0	453,375	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,753	0	0	771,638	1,721	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,566	1,197,128	0	2,618,005	15,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,779	0	16,474	794	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,447	714,387	0	844,370	21,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,805	17,199,269	0	1,946,349	5,639	54.00
60.00	06000	LABORATORY	411,771	17,981,223	0	1,765,975	2,452	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	32,450	269,786	0	40,901	0	63.00
65.00	06500	RESPIRATORY THERAPY	21,239	3,262,334	0	558,254	3,395	65.00
66.00	06600	PHYSICAL THERAPY	9,059	3,937,840	0	1,005,695	3,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	719,164	0	41,943	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,455,501	0	238,760	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	122,733	1,084,137	0	249,941	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,786	10,336	0	16,642	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	364,605	5,264,368	0	521,426	677	73.00
76.00	03610	SLEEP LAB	56	81,513	0	1,569	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,402	588,221	0	231,367	1,161	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	RURAL HEALTH CLINIC	40,649	477,060	0	716,666	3,600	88.00
91.00	09100	EMERGENCY	164,128	14,443,558	0	2,914,413	7,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,534,047	68,712,604	-2,317,860	16,978,976	71,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	5,847	675	190.00
190.01	19001	MARKETING	0	0	0	62,895	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	244,632	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	19,542	2,256	194.00
194.01	07951	MEDICAL SPECIALTY	2,038	0	0	191,205	2,261	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	36,563	14,785	194.02
194.03	07953	VA PROPERTY	0	0	0	24,730	10,000	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	78,245	343,308		2,317,860	1,126,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.050938	0.004996		0.131964	11.126027	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,875	6,133		209,403	49,532	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012288	0.000089		0.011922	0.489099	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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (CAF))	NURSING ADMINISTRATION (HOURS SUPERVI)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	1,479					9.00
10.00	01000	DIETARY	0	6,289				10.00
11.00	01100	CAFETERIA	19	0	170,188			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,080	2,080		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,676	0	1,359,135	14.00
15.00	01500	PHARMACY	0	0	4,483	50	13,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40	0	11,684	444	1,753	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386	5,718	40,383	558	81,566	30.00
31.00	03100	INTENSIVE CARE UNIT	56	51	1,063	42	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	280	0	6,439	327	41,447	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	20,653	0	34,805	54.00
60.00	06000	LABORATORY	112	0	21,381	0	411,771	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	1,154	0	32,450	63.00
65.00	06500	RESPIRATORY THERAPY	56	0	10,640	41	21,239	65.00
66.00	06600	PHYSICAL THERAPY	80	0	10,453	0	9,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,445	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32	0	2,988	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	122,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	0	0	0	364,605	73.00
76.00	03610	SLEEP LAB	0	0	440	0	56	76.00
76.97	07697	CARDIAC REHABILITATION	20	0	1,871	50	1,402	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	RURAL HEALTH CLINIC	0	0	0	0	40,649	88.00
91.00	09100	EMERGENCY	310	520	28,765	568	164,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,479	6,289	169,598	2,080	1,357,097	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	590	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	0	0	2,038	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	529,051	227,619	266,132	68,426	142,402	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	357.708587	36.193194	1.563753	32.897115	0.104774	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,315	27,249	14,895	868	1,969	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (CAF))	NURSING ADMINISTRATION (HOURS SUPERVI)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	9.678837	4.332803	0.087521	0.417308	0.001449	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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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
5.01	00550	DATA PROCESSING				5.01
5.02	00570	ADMITTING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
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	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,712,604		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,197,128		30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,779		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	714,387		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,199,269		54.00
60.00	06000	LABORATORY	0	17,981,223		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	269,786		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,262,334		65.00
66.00	06600	PHYSICAL THERAPY	0	3,937,840		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	719,164		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,455,501		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,084,137		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,336		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	5,264,368		73.00
76.00	03610	SLEEP LAB	0	81,513		76.00
76.97	07697	CARDIAC REHABILITATION	0	588,221		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	RURAL HEALTH CLINIC	0	477,060		88.00
91.00	09100	EMERGENCY	0	14,443,558		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	68,712,604		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	0		190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	0		194.00
194.01	07951	MEDICAL SPECIALTY	0	0		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	0		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	0		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
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)	523,289	939,983		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,232.890000	0.013680		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,365	27,007		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 6:51 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
			15.00	16.00				
205.00		Unit cost multiplier (Wkst. B, Part II)	63.650000	0.000393				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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,582,147		3,582,147	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	52,770		52,770	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,328,448		1,328,448	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,561,490		2,561,490	0	0	54.00
60.00	06000	LABORATORY	2,388,918		2,388,918	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	55,194		55,194	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	754,569	0	754,569	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,276,556	0	1,276,556	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,139	0	61,139	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	306,298		306,298	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,614		310,614	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,633		20,633	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,238,428		1,238,428	0	0	73.00
76.00	03610	SLEEP LAB	3,585		3,585	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	294,735		294,735	0	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	RURAL HEALTH CLINIC	862,079		862,079	0	0	88.00
91.00	09100	EMERGENCY	3,787,318		3,787,318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,710		711,710		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,596,631	0	19,596,631	0	0	200.00
201.00		Less Observation Beds	711,710		711,710		0	201.00
202.00		Total (see instructions)	18,884,921	0	18,884,921	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,197,128		1,197,128			30.00
31.00	03100	INTENSIVE CARE UNIT	26,779		26,779			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,976	662,411	714,387	1.859564	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	476,273	16,722,996	17,199,269	0.148930	0.000000	54.00
60.00	06000	LABORATORY	1,351,107	16,630,116	17,981,223	0.132856	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	48,739	221,047	269,786	0.204584	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	646,509	2,615,825	3,262,334	0.231297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	643,888	3,293,952	3,937,840	0.324177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,949	376,215	719,164	0.085014	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	106,871	1,348,630	1,455,501	0.210442	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	926,528	157,609	1,084,137	0.286508	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,336	10,336	1.996227	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,232,665	4,031,703	5,264,368	0.235247	0.000000	73.00
76.00	03610	SLEEP LAB	0	81,513	81,513	0.043981	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	588,221	588,221	0.501062	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	RURAL HEALTH CLINIC	0	477,060	477,060			88.00
91.00	09100	EMERGENCY	502,509	13,941,049	14,443,558	0.262215	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,817	310,715	330,532	2.153226	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,573,738	61,469,398	69,043,136			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,573,738	61,469,398	69,043,136			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
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	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,582,147		3,582,147	0	3,582,147	30.00
31.00	03100	INTENSIVE CARE UNIT	52,770		52,770	0	52,770	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,328,448		1,328,448	0	1,328,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,561,490		2,561,490	0	2,561,490	54.00
60.00	06000	LABORATORY	2,388,918		2,388,918	0	2,388,918	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	55,194		55,194	0	55,194	63.00
65.00	06500	RESPIRATORY THERAPY	754,569	0	754,569	0	754,569	65.00
66.00	06600	PHYSICAL THERAPY	1,276,556	0	1,276,556	0	1,276,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,139	0	61,139	0	61,139	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	306,298		306,298	0	306,298	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,614		310,614	0	310,614	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,633		20,633	0	20,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,238,428		1,238,428	0	1,238,428	73.00
76.00	03610	SLEEP LAB	3,585		3,585	0	3,585	76.00
76.97	07697	CARDIAC REHABILITATION	294,735		294,735	0	294,735	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	RURAL HEALTH CLINIC	862,079		862,079	0	862,079	88.00
91.00	09100	EMERGENCY	3,787,318		3,787,318	0	3,787,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,710		711,710		711,710	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,596,631	0	19,596,631	0	19,596,631	200.00
201.00		Less Observation Beds	711,710		711,710		711,710	201.00
202.00		Total (see instructions)	18,884,921	0	18,884,921	0	18,884,921	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,197,128		1,197,128			30.00
31.00	03100	INTENSIVE CARE UNIT	26,779		26,779			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,976	662,411	714,387	1.859564	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	476,273	16,722,996	17,199,269	0.148930	0.000000	54.00
60.00	06000	LABORATORY	1,351,107	16,630,116	17,981,223	0.132856	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	48,739	221,047	269,786	0.204584	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	646,509	2,615,825	3,262,334	0.231297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	643,888	3,293,952	3,937,840	0.324177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,949	376,215	719,164	0.085014	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	106,871	1,348,630	1,455,501	0.210442	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	926,528	157,609	1,084,137	0.286508	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,336	10,336	1.996227	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,232,665	4,031,703	5,264,368	0.235247	0.000000	73.00
76.00	03610	SLEEP LAB	0	81,513	81,513	0.043981	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	588,221	588,221	0.501062	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	RURAL HEALTH CLINIC	0	477,060	477,060	1.807066	0.000000	88.00
91.00	09100	EMERGENCY	502,509	13,941,049	14,443,558	0.262215	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,817	310,715	330,532	2.153226	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,573,738	61,469,398	69,043,136			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,573,738	61,469,398	69,043,136			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
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	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	210,641	714,387	0.294856	18,623	5,491	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,750	17,199,269	0.005160	120,985	624	54.00
60.00	06000	LABORATORY	66,914	17,981,223	0.003721	381,819	1,421	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	1,373	269,786	0.005089	3,574	18	63.00
65.00	06500	RESPIRATORY THERAPY	43,834	3,262,334	0.013436	143,242	1,925	65.00
66.00	06600	PHYSICAL THERAPY	50,358	3,937,840	0.012788	64,913	830	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,523	719,164	0.003508	39,965	140	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,576	1,455,501	0.003144	52,651	166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,138	1,084,137	0.008429	233,898	1,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	420	10,336	0.040635	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,771	5,264,368	0.006035	292,986	1,768	73.00
76.00	03610	SLEEP LAB	98	81,513	0.001202	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,463	588,221	0.024588	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	RURAL HEALTH CLINIC	42,875	477,060	0.089873	0	0	88.00
91.00	09100	EMERGENCY	120,595	14,443,558	0.008349	110,885	926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,439	330,532	0.125371	5,117	642	92.00
200.00		Total (lines 50 through 199)	729,768	67,819,229		1,468,658	15,923	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
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	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	714,387	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,199,269	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,981,223	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	269,786	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,262,334	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,937,840	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	719,164	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,455,501	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,084,137	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,336	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,264,368	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	81,513	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	588,221	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	RURAL HEALTH CLINIC	0	0	0	477,060	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	14,443,558	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	330,532	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,819,229		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	18,623	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	120,985	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	381,819	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	3,574	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	143,242	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	64,913	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	39,965	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	52,651	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	233,898	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	292,986	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	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	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	110,885	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,117	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,468,658	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.859564	0	119,485	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148930	0	3,006,612	0	0	54.00
60.00	06000	LABORATORY	0.132856	0	3,062,290	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.204584	0	29,881	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.231297	0	583,491	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324177	0	862,157	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.085014	0	81,981	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210442	0	393,421	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286508	0	106,126	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.996227	0	2,720	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235247	0	985,693	838	0	73.00
76.00	03610	SLEEP LAB	0.043981	0	17,303	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501062	0	179,243	0	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	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.262215	0	1,632,635	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.153226	0	65,700	0	0	92.00
200.00		Subtotal (see instructions)		0	11,128,738	838	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	11,128,738	838	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	222,190	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,775	0		54.00
60.00	06000	LABORATORY	406,844	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	6,113	0		63.00
65.00	06500	RESPIRATORY THERAPY	134,960	0		65.00
66.00	06600	PHYSICAL THERAPY	279,491	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,970	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	82,792	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,406	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,430	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	231,881	197		73.00
76.00	03610	SLEEP LAB	761	0		76.00
76.97	07697	CARDIAC REHABILITATION	89,812	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	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	428,101	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	141,467	0		92.00
200.00		Subtotal (see instructions)	2,514,993	197		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,514,993	197		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.859564	0	10,888	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148930	0	323,720	0	0	54.00
60.00	06000	LABORATORY	0.132856	0	294,923	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.204584	0	831	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.231297	0	43,774	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324177	0	17,466	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.085014	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210442	0	24,629	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286508	0	4,095	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.996227	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235247	0	57,821	0	0	73.00
76.00	03610	SLEEP LAB	0.043981	0	1,615	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501062	0	5,388	0	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	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.262215	0	366,587	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.153226	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	1,151,737	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,151,737	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	20,247	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,212	0		54.00
60.00	06000	LABORATORY	39,182	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	170	0		63.00
65.00	06500	RESPIRATORY THERAPY	10,125	0		65.00
66.00	06600	PHYSICAL THERAPY	5,662	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	5,183	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,173	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,602	0		73.00
76.00	03610	SLEEP LAB	71	0		76.00
76.97	07697	CARDIAC REHABILITATION	2,700	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	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	96,125	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	242,452	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	242,452	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,332	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,245	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)	814	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	893	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	194	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)	334	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)	420	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,582,147	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	51,666	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,526,277	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,055,870	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,055,870	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)	1,651.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	551,534	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)	551,534	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	52,770	749	70.45	5	352	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)	348,791	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)	900,677	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	693,546	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	693,546	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)	431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,651.30	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	711,710	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	208,571	3,582,147	0.058225	711,710	41,439	90.00
91.00	Nursing Program cost	0	3,582,147	0.000000	711,710	0	91.00
92.00	Allied health cost	0	3,582,147	0.000000	711,710	0	92.00
93.00	All other Medical Education	0	3,582,147	0.000000	711,710	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,332	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,245	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)	814	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	893	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	194	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)	14	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	3,582,147	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	51,666	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,526,277	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,055,870	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,055,870	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)	1,651.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,118	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)	23,118	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	52,770	749	70.45	1	70	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)	18,815	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)	42,003	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,651.30	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	711,710	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	208,571	3,582,147	0.058225	711,710	41,439	90.00
91.00	Nursing Program cost	0	3,582,147	0.000000	711,710	0	91.00
92.00	Allied health cost	0	3,582,147	0.000000	711,710	0	92.00
93.00	All other Medical Education	0	3,582,147	0.000000	711,710	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		297,527		30.00
31.00	03100	INTENSIVE CARE UNIT		7,620		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.859564	18,623	34,631	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148930	120,985	18,018	54.00
60.00	06000	LABORATORY	0.132856	381,819	50,727	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.204584	3,574	731	63.00
65.00	06500	RESPIRATORY THERAPY	0.231297	143,242	33,131	65.00
66.00	06600	PHYSICAL THERAPY	0.324177	64,913	21,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.085014	39,965	3,398	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210442	52,651	11,080	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286508	233,898	67,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.996227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235247	292,986	68,924	73.00
76.00	03610	SLEEP LAB	0.043981	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501062	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	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.262215	110,885	29,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.153226	5,117	11,018	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,468,658	348,791	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,468,658		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z334 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.859564	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148930	22,106	3,292	54.00
60.00	06000	LABORATORY	0.132856	140,010	18,601	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.204584	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.231297	13,436	3,108	65.00
66.00	06600	PHYSICAL THERAPY	0.324177	205,631	66,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.085014	98,457	8,370	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210442	52,892	11,131	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286508	174,726	50,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.996227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235247	200,689	47,211	73.00
76.00	03610	SLEEP LAB	0.043981	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501062	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	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.262215	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.153226	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		907,947	208,434	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)		907,947		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 6:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		75,941		30.00
31.00	03100	INTENSIVE CARE UNIT		1,524		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.859564	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148930	5,173	770	54.00
60.00	06000	LABORATORY	0.132856	19,942	2,649	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.204584	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.231297	35,068	8,111	65.00
66.00	06600	PHYSICAL THERAPY	0.324177	775	251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.085014	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.210442	1,328	279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286508	72	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.996227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235247	9,343	2,198	73.00
76.00	03610	SLEEP LAB	0.043981	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501062	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	RURAL HEALTH CLINIC	1.807066	0	0	88.00
91.00	09100	EMERGENCY	0.262215	17,298	4,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.153226	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		88,999	18,815	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)		88,999		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,515,190	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,515,190	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	2,540,342	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	36,234	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,550,659	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)	953,449	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)	953,449	30.00
31.00	Primary payer payments	551	31.00
32.00	Subtotal (line 30 minus line 31)	952,898	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)	145,683	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,694	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,050	36.00
37.00	Subtotal (see instructions)	1,047,592	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,047,592	40.00
40.01	Sequestration adjustment (see instructions)	20,952	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	788,375	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)	238,265	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	50,989	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: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		433,032		788,375	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)		433,032		788,375	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		300,925		238,265	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		733,957		1,026,640	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: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		481,797		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)		481,797		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		398,634		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		880,431		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: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/31/2024 6:51 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	700,481	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)	210,518	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	420	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)	910,999	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	910,999	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)	910,999	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	898,399	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)	898,399	0	19.00
19.01	Sequestration adjustment (see instructions)	17,968	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	481,797	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)	398,634	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	900,677	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	900,677	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	909,684	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	909,684	19.00
20.00	Deductibles (exclude professional component)	170,994	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	738,690	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	738,690	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,763	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,246	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	748,936	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	748,936	30.00
30.01	Sequestration adjustment (see instructions)	14,979	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	433,032	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	300,925	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,517	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 6:51 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	42,003		1.00
2.00	Medical and other services		242,452	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	42,003	242,452	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	42,003	242,452	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	88,999	1,151,737	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	88,999	1,151,737	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	88,999	1,151,737	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	46,996	909,285	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	42,003	242,452	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	42,003	242,452	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	42,003	242,452	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	42,003	242,452	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	42,003	242,452	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	42,003	242,452	40.00
41.00	Interim payments	42,003	242,452	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 6:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	248,278	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,114,530	0	0	0	4.00
5.00	Other receivable	236,033	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,277,819	0	0	0	6.00
7.00	Inventory	486,420	0	0	0	7.00
8.00	Prepaid expenses	172,671	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,980,113	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	428,000	0	0	0	12.00
13.00	Land improvements	37,764	0	0	0	13.00
14.00	Accumulated depreciation	-633	0	0	0	14.00
15.00	Buildings	2,538,613	0	0	0	15.00
16.00	Accumulated depreciation	-53,941	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	464,137	0	0	0	19.00
20.00	Accumulated depreciation	-13,373	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	640,306	0	0	0	23.00
24.00	Accumulated depreciation	-71,056	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,969,817	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-9,019,205	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-9,019,205	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	-1,069,275	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	-607,630	0	0	0	37.00
38.00	Salaries, wages, and fees payable	393,839	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	3,226	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	94,195	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-116,370	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	172,867	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	172,867	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	56,497	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,125,772				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)	-1,125,772	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	-1,069,275	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 6:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,861,928				2.00
3.00	Total (sum of line 1 and line 2)		-2,861,928		0		3.00
4.00	UNEXPLAINED VARIANCE	2,156		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)		2,156		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,859,772		0		11.00
12.00	SCOTT NET INCOME BEFORE NORTON ACQUI	-1,734,000		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)		-1,734,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,125,772		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	UNEXPLAINED VARIANCE		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	SCOTT NET INCOME BEFORE NORTON ACQUI		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: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2024 6:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,378,685		3,378,685	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)	3,378,685		3,378,685	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	26,779		26,779	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)	26,779		26,779	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,405,464		3,405,464	17.00
18.00	Ancillary services	3,723,828	48,539,746	52,263,574	18.00
19.00	Outpatient services	379,084	12,517,955	12,897,039	19.00
20.00	RURAL HEALTH CLINIC	0	477,060	477,060	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	510,058	510,058	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,508,376	62,044,819	69,553,195	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,626,740		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)		22,626,740		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/31/2024 6:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	69,553,195	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,846,960	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,706,235	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,626,740	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,920,505	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,058,577	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,058,577	25.00
26.00	Total (line 5 plus line 25)	-2,861,928	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,861,928	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 6:51 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	78,749	0	78,749	0	78,749	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	180,492	0	180,492	0	180,492	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	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	259,241	0	259,241	0	259,241	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	3,407	3,407	0	3,407	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,407	3,407	0	3,407	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	259,241	3,407	262,648	0	262,648	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,662	8,662	0	8,662	29.00
30.00	Administrative Costs	81,512	236,229	317,741	-51,863	265,878	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	81,512	244,891	326,403	-51,863	274,540	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	340,753	248,298	589,051	-51,863	537,188	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 6:51 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	78,749		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	180,492		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	259,241		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	3,407		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,407		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	262,648		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8,662		29.00
30.00	Administrative Costs	0	265,878		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	274,540		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	537,188		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 6:51 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.03	2,084	2,100	2,163		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.03	2,084		2,163	2,163	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)	1.03	2,084			2,163	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)	262,648	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)	262,648	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)	274,540	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	324,891	15.00
16.00	Total overhead (sum of lines 14 and 15)	599,431	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	599,431	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	599,431	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	862,079	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		862,079	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		862,079	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,163	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)		2,163	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		398.56	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	224.08	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	224.08	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	419	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	93,890	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	93,890	16.00
16.01	Total program charges (see instructions)(from contractor's records)		93,060	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		221	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		223	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.)		64,673	16.04
16.05	Total program cost (see instructions)	0	64,896	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,826	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,003	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		64,896	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)		64,896	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)		64,896	26.00
26.01	Sequestration adjustment (see instructions)		1,298	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		63,578	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)		20	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 6:51 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		63,578	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)		63,578	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		20	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		63,598	7.00

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