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: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/23/2024 11:12 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/23/2024 Time: 11:12 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 SULLIVAN COUNTY COMMUNITY HOSPITAL (15-1327) 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				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	335,898	-40,816	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	32,196	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		14,444		0	10.00
200.00	TOTAL	0	368,094	-26,372	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 11:12 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2200 NORTH SECTION STREET	PO Box: 10			1.00
2.00	City: SULLIVAN	State: IN	Zip Code: 47882	County: SULLIVAN	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	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	FAMILY PRACTICE ASSOCIATES	158540	45460		10/01/2019	N	N	N	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)	9		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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 11:12 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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 11:12 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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 11:12 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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 11:12 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)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 11:12 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	345,472	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	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		140.00

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

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

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

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N	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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2024 11:12 am

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/03/2024	Y	04/03/2024	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)	Y	04/03/2024	Y	04/03/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 11:12 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.	Y	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	Y	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JIM	BISHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	SULLIVAN COUNTY COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812 268-4311	JIM.BISHOP@SCHOSP.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.	CFO		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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2024 11:12 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	29,304.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	29,304.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	29,304.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2024 11:12 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)	509	104	1,221			1.00
2.00	HMO and other (see instructions)	0	0				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	75	0	75			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	25			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	584	104	1,321			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		142	223			13.00
14.00	Total (see instructions)	584	246	1,544	0.00	374.35	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,793	0	17,891	0.00	16.00	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	390.35	27.00
28.00	Observation Bed Days		54	1,524			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			36			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	22			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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2024 11:12 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	146	28	392	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	146	28	392	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 11:12 am

RHC I

				1.00	
	Clinic Address and Identification				
1.00	Street			2229 MARY SHERMAN DRIVE	1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SULLIVAN	IN	47882	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

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

			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0	13.00
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: 15-1327 Component CCN: 15-8540	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/23/2024 11:12 am
		RHC I	

			County				
			4.00				
2.00	City, State, ZIP Code, County		SULLIVAN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	05:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 11:12 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)	0.287955	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,553,187	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	764,241	5.00
6.00	Medicaid charges	39,949,245	6.00
7.00	Medicaid cost (line 1 times line 6)	11,503,585	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	186,157	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)	1,228,549	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	17,053,396	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,910,611	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	3,682,062	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)	3,868,219	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)	114,860	592,463	707,323	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	33,075	592,463	625,538	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,884	9,716	11,600	22.00
23.00	Cost of charity care (see instructions)	31,191	582,747	613,938	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)	2,572,573	26.00
27.00	Medicare reimbursable bad debts (see instructions)	762,139	27.00
27.01	Medicare allowable bad debts (see instructions)	1,172,522	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,400,051	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	813,535	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,427,473	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,295,692	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 11:12 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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/23/2024 11:12 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		600,716	600,716	202,646	803,362	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,230,101	1,230,101	21,677	1,251,778	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	203,054	7,575,675	7,778,729	0	7,778,729	4.00
5.01	00590	IS/ACCOUNTING/MARKETING	743,068	849,030	1,592,098	0	1,592,098	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	1,255,585	2,290,458	3,546,043	0	3,546,043	5.02
5.03	00592	OTHER A&G	1,733,646	2,481,163	4,214,809	703,238	4,918,047	5.03
7.00	00700	OPERATION OF PLANT	492,298	927,378	1,419,676	50,512	1,470,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,511	23,290	92,801	0	92,801	8.00
9.00	00900	HOUSEKEEPING	574,562	39,989	614,551	0	614,551	9.00
10.00	01000	DIETARY	500,708	337,108	837,816	0	837,816	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	471,412	70,385	541,797	0	541,797	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	173,156	24,674	197,830	0	197,830	14.00
15.00	01500	PHARMACY	525,573	2,944,391	3,469,964	-4,211	3,465,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	610,498	27,305	637,803	0	637,803	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	930,000	930,000	0	930,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,773,846	633,200	4,407,046	176,764	4,583,810	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,515	25,515	-25,515	0	31.00
43.00	04300	NURSERY	0	0	0	265,161	265,161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,163,731	1,919,810	5,083,541	-2,364,507	2,719,034	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	647,770	639,750	1,287,520	-1,159,661	127,859	52.00
53.00	05300	ANESTHESIOLOGY	0	28,087	28,087	-24,670	3,417	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	770,238	508,178	1,278,416	-29,253	1,249,163	54.00
54.01	05401	ULTRASOUND	186,052	39,070	225,122	-1,567	223,555	54.01
56.00	05600	RADIOISOTOPE	0	170,153	170,153	-54,528	115,625	56.00
60.00	06000	LABORATORY	1,003,389	1,387,014	2,390,403	-33,198	2,357,205	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	13,533	13,533	-13,533	0	64.00
65.00	06500	RESPIRATORY THERAPY	555,692	108,497	664,189	-51,942	612,247	65.00
66.00	06600	PHYSICAL THERAPY	784,535	28,882	813,417	-3,544	809,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	230,941	3,294	234,235	-315	233,920	67.00
68.00	06800	SPEECH PATHOLOGY	95,476	1,863	97,339	0	97,339	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,810	3,810	0	3,810	70.00
70.01	07001	CARDIOPULMONARY	92,152	2,934	95,086	-137	94,949	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	105,520	105,520	1,078,189	1,183,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	718,737	718,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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	1,859,736	535,083	2,394,819	-93,298	2,301,521	88.00
90.00	09000	CLINIC	14,594	61,764	76,358	-10	76,348	90.00
90.01	09001	PAIN MANAGEMENT	2,086,668	31,332	2,118,000	3,501	2,121,501	90.01
90.02	09002	CLINIC - LAKESIDE	1,065,087	354,773	1,419,860	-92,077	1,327,783	90.02
90.03	09003	CLINIC - QUICKCARE	712,868	150,782	863,650	13,288	876,938	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	0	0	691,410	691,410	90.04
90.05	09005	ORTHO CLINIC	0	0	0	298,605	298,605	90.05
91.00	09100	EMERGENCY	1,042,882	1,583,626	2,626,508	-4,257	2,622,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	543,427	502,366	1,045,793	-130,760	915,033	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,982,155	29,190,499	55,172,654	136,745	55,309,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	209,790	209,790	-123,570	86,220	192.00
192.01	19201	MSO CLINICS	370,159	244,380	614,539	-12,452	602,087	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	197,417	96,436	293,853	0	293,853	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	18,916	3,513	22,429	0	22,429	194.03
194.04	07954	TH PAIN	331,713	66,948	398,661	-723	397,938	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	26,900,360	29,811,566	56,711,926	0	56,711,926	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/23/2024 11:12 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	-133,798	669,564		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,823	1,248,955		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-832,452	6,946,277		4.00
5.01	00590	IS/ACCOUNTING/MARKETING	-3,785	1,588,313		5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	-1,860,466	1,685,577		5.02
5.03	00592	OTHER A&G	-714,162	4,203,885		5.03
7.00	00700	OPERATION OF PLANT	-10,740	1,459,448		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,801		8.00
9.00	00900	HOUSEKEEPING	0	614,551		9.00
10.00	01000	DIETARY	-202,311	635,505		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-10,684	531,113		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-882	196,948		14.00
15.00	01500	PHARMACY	-1,616,459	1,849,294		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,111	633,692		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-930,000	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-656,946	3,926,864		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	265,161		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-680,275	2,038,759		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	127,859		52.00
53.00	05300	ANESTHESIOLOGY	-1,053	2,364		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-56,582	1,192,581		54.00
54.01	05401	ULTRASOUND	0	223,555		54.01
56.00	05600	RADIOISOTOPE	-4,792	110,833		56.00
60.00	06000	LABORATORY	-67,863	2,289,342		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-7,112	605,135		65.00
66.00	06600	PHYSICAL THERAPY	-34,057	775,816		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	233,920		67.00
68.00	06800	SPEECH PATHOLOGY	0	97,339		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,810		70.00
70.01	07001	CARDIOPULMONARY	-46,481	48,468		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-17,166	1,166,543		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	718,737		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-60,896	-60,896		73.00
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	-337	2,301,184		88.00
90.00	09000	CLINIC	-16,377	59,971		90.00
90.01	09001	PAIN MANAGEMENT	-1,392,413	729,088		90.01
90.02	09002	CLINIC - LAKESIDE	-827,486	500,297		90.02
90.03	09003	CLINIC - QUICKCARE	-476,227	400,711		90.03
90.04	09004	WOMENS HEALTH CLINIC	-473,413	217,997		90.04
90.05	09005	ORTHO CLINIC	-134,248	164,357		90.05
91.00	09100	EMERGENCY	-33,368	2,588,883		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	BEHAVIOR HEALTH	-406,663	508,370		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,716,428	43,592,971		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,220		192.00
192.01	19201	MSO CLINICS	0	602,087		192.01
192.03	19203	FPA	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0		194.00
194.01	07951	WELLNESS CLINIC	-3,861	289,992		194.01
194.02	07952	OTHER (SPECIFY)	0	0		194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	22,429		194.03
194.04	07954	TH PAIN	0	397,938		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,720,289	44,991,637		200.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 11:12 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CARE COORDINATION RECLASS				
1.00	OTHER A&G	5.03	625,566	77,672	1.00
	TOTALS		625,566	77,672	
	B - DELIVERY ROOM RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	447,751	432,043	1.00
2.00	NURSERY	43.00	134,948	130,213	2.00
	TOTALS		582,699	562,256	
	C - OXYGEN RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	41,695	1.00
	TOTALS		0	41,695	
	D - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,036,494	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	718,737	2.00
3.00	PAIN MANAGEMENT	90.01	0	3,501	3.00
4.00	CLINIC - QUICKCARE	90.03	0	13,288	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	1,772,020	
	E - BEHAVIOR HEALTH OVERHEAD				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	99,526	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,677	2.00
3.00	OPERATION OF PLANT	7.00	0	9,557	3.00
	TOTALS		0	130,760	
	F - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	11,415	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	11,415	
	G - PRIVATE PHYSICIAN RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	94,030	1.00
2.00	OPERATION OF PLANT	7.00	0	29,540	2.00
	TOTALS		0	123,570	
	H - ICU RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	25,515	1.00
	TOTALS		0	25,515	
	I - WOMENS HEALTH RECLASS				
1.00	WOMENS HEALTH CLINIC	90.04	575,638	146,732	1.00
	TOTALS		575,638	146,732	
	J - ORTHO CLINIC RECLASS				
1.00	ORTHO CLINIC	90.05	271,087	28,877	1.00
	TOTALS		271,087	28,877	
	K - IV RECLASS				
1.00	OPERATING ROOM	50.00	0	1,643	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,890	2.00
	TOTALS		0	13,533	
	L - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,090	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	9,090	
500.00	Grand Total: Increases		2,054,990	2,943,135	500.00

RECLASSIFICATIONS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 11:12 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CARE COORDINATION RECLASS						
1.00	OPERATING ROOM	50.00	625,566	77,672	0		1.00
	TOTALS		625,566	77,672			
	B - DELIVERY ROOM RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	582,699	562,256	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		582,699	562,256			
	C - OXYGEN RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	41,695	0		1.00
	TOTALS		0	41,695			
	D - MEDICAL SUPPLIES RECLASS						
1.00	PHARMACY	15.00	0	689	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,039	0		2.00
3.00	OPERATING ROOM	50.00	0	1,361,722	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,706	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	24,670	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,253	0		6.00
7.00	ULTRASOUND	54.01	0	1,567	0		7.00
8.00	RADIOISOTOPE	56.00	0	54,528	0		8.00
9.00	LABORATORY	60.00	0	33,198	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	10,247	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	3,544	0		11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	315	0		12.00
13.00	CARDIOPULMONARY	70.01	0	137	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,890	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	88,434	0		15.00
16.00	CLINIC	90.00	0	10	0		16.00
17.00	CLINIC - LAKESIDE	90.02	0	84,024	0		17.00
18.00	WOMENS HEALTH CLINIC	90.04	0	30,960	0		18.00
19.00	ORTHO CLINIC	90.05	0	1,359	0		19.00
20.00	EMERGENCY	91.00	0	4,257	0		20.00
21.00	MSO CLINICS	192.01	0	12,452	0		21.00
22.00	TH PAIN	194.04	0	19	0		22.00
	TOTALS		0	1,772,020			
	E - BEHAVIOR HEALTH OVERHEAD						
1.00	BEHAVIOR HEALTH	93.00	0	130,760	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	130,760			
	F - UTILITIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	2,136	0		1.00
2.00	OPERATING ROOM	50.00	0	1,226	0		2.00
3.00	CLINIC - LAKESIDE	90.02	0	8,053	0		3.00
	TOTALS		0	11,415			
	G - PRIVATE PHYSICIAN RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	123,570	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	123,570			
	H - ICU RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	0	25,515	0		1.00
	TOTALS		0	25,515			
	I - WOMENS HEALTH RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	575,638	146,732	0		1.00
	TOTALS		575,638	146,732			
	J - ORTHO CLINIC RECLASS						
1.00	OPERATING ROOM	50.00	271,087	28,877	0		1.00
	TOTALS		271,087	28,877			
	K - IV RECLASS						
1.00	INTRAVENOUS THERAPY	64.00	0	13,533	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	13,533			
	L - INTEREST EXPENSE						
1.00	PHARMACY	15.00	0	3,522	11		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	4,864	0		2.00
3.00	TH PAIN	194.04	0	704	0		3.00
	TOTALS		0	9,090			
500.00	Grand Total: Decreases		2,054,990	2,943,135			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2024 11:12 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,036,127	0	0	0	0	1.00
2.00	Land Improvements	3,113,955	575,825	0	575,825	0	2.00
3.00	Buildings and Fixtures	17,200,880	2,887,074	0	2,887,074	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,641,566	0	0	0	0	5.00
6.00	Movable Equipment	24,062,501	1,347,068	0	1,347,068	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,055,029	4,809,967	0	4,809,967	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,055,029	4,809,967	0	4,809,967	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,036,127	0	1.00
2.00	Land Improvements	3,689,780	0	2.00
3.00	Buildings and Fixtures	20,087,954	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	6,641,566	0	5.00
6.00	Movable Equipment	25,409,569	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,864,996	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	56,864,996	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/23/2024 11:12 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	487,870	0	112,846	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,236,436	-6,335	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,724,306	-6,335	112,846	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	600,716		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,230,101		2.00
3.00	Total (sum of lines 1-2)	0	1,830,817		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2024 11:12 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	31,455,427	0	31,455,427	0.553160	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,409,569	0	25,409,569	0.446840	0	2.00
3.00	Total (sum of lines 1-2)	56,864,996	0	56,864,996	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	681,426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,258,113	-6,335	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,939,539	-6,335	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	-11,862	0	0	0	669,564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-2,823	0	0	0	1,248,955	2.00
3.00	Total (sum of lines 1-2)	-14,685	0	0	0	1,918,519	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/23/2024 11:12 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	-138,505	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)	A	-9,784	OTHER A&G	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,232	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,859,321			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	-15,017			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-202,311	DIETARY	10.00	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	B	-140	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-999	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,111	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/23/2024 11:12 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	A&G - ADVERTISING	A	-296,984	OTHER A&G	5.03	0	33.00
33.01	PAIN MGMT ADVERTISING	A	0	PAIN MANAGEMENT	90.01	0	33.01
33.02	BEHAVIORAL HEALTH ADVERTISING	A	-3,928	BEHAVIOR HEALTH	93.00	0	33.02
33.03	ORTHO ADVERTISING	A	-10	OPERATING ROOM	50.00	0	33.03
33.04	TH PAIN ADVERTISING	A	0	TH PAIN	194.04	0	33.04
33.05	PHYSICIAN RECRUITMENT	A	-165,298	OTHER A&G	5.03	0	33.05
33.06	FLOWERS & PLANTS	A	-2,276	OTHER A&G	5.03	0	33.06
33.07	SURETY BONDS	A	-279	OTHER A&G	5.03	0	33.07
33.08	SALES TAX	A	0	OTHER A&G	5.03	0	33.08
33.09	LAKESIDE ADVERTISING	A	-302	CLINIC - LAKESIDE	90.02	0	33.09
33.10	QUICKCARE ADVERTISING	A	-970	CLINIC - QUICKCARE	90.03	0	33.10
33.11	SURETY BONDS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	LOBBYING EXPENSES	A	-2,767	OTHER A&G	5.03	0	33.12
33.13	DOMESTIC HEALTHCARE CLAIMS	B	-683,368	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	MISC INCOME	B	-1,811	OTHER A&G	5.03	0	33.14
33.15	MISC INCOME	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	MISC EDUCATION REVENUE	B	-10,684	NURSING ADMINISTRATION	13.00	0	33.16
33.17	340B REVENUE (OFFSET TO EXTENT OF EX	A	-1,615,460	PHARMACY	15.00	0	33.17
33.18	BOND ISSUANCE COST	A	4,707	CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.19	BEHAVIORAL HEALTH - START-UP COSTS	A	0	BEHAVIOR HEALTH	93.00	0	33.19
33.20	BEHAVIORAL HEALTH - START-UP COSTS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	HOSPITAL ASSESSMENT FEE	B	-1,860,149	BUSINESS OFFICE & ADMITTING	5.02	0	33.21
33.22	CRNA EXPENSES	A	-930,000	NONPHYSICIAN ANESTHETISTS	19.00	0	33.22
33.23	FPA ADVERTISING EXPENSE	A	-337	RURAL HEALTH CLINIC	88.00	0	33.23
33.24	INTEREST INCOME	B	-317	BUSINESS OFFICE & ADMITTING	5.02	0	33.24
33.25	PHYSICIAN BENEFITS	A	-117,936	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	COST OF EMPLOYEE SELF INSURANCE	A	-242,169	ADULTS & PEDIATRICS	30.00	0	33.26
33.27	COST OF EMPLOYEE SELF INSURANCE	A	-127,774	OPERATING ROOM	50.00	0	33.27
33.28	COST OF EMPLOYEE SELF INSURANCE	A	-1,053	ANESTHESIOLOGY	53.00	0	33.28
33.29	COST OF EMPLOYEE SELF INSURANCE	A	-56,582	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	COST OF EMPLOYEE SELF INSURANCE	A	-4,792	RADIOISOTOPE	56.00	0	33.30
33.31	COST OF EMPLOYEE SELF INSURANCE	A	-67,863	LABORATORY	60.00	0	33.31
33.32	COST OF EMPLOYEE SELF INSURANCE	A	-7,112	RESPIRATORY THERAPY	65.00	0	33.32
33.33	COST OF EMPLOYEE SELF INSURANCE	A	-34,057	PHYSICAL THERAPY	66.00	0	33.33
33.34	COST OF EMPLOYEE SELF INSURANCE	A	-45,896	CARDIOPULMONARY	70.01	0	33.34
33.35	COST OF EMPLOYEE SELF INSURANCE	A	-17,026	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.35
33.36	COST OF EMPLOYEE SELF INSURANCE	A	-60,896	DRUGS CHARGED TO PATIENTS	73.00	0	33.36
33.37	COST OF EMPLOYEE SELF INSURANCE	A	-33,368	EMERGENCY	91.00	0	33.37
33.38	LAKESIDE BAD DEBTS	A	-20,895	CLINIC - LAKESIDE	90.02	0	33.38
33.39	QUICKCARE BAD DEBTS	A	4,794	CLINIC - QUICKCARE	90.03	0	33.39
33.40	ADD'L TPA ALLOWABLE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
33.41	CARD/PULM ADVERTISING	A	-585	CARDIOPULMONARY	70.01	0	33.41
33.42	FIT FITNESS ADVERTISING	A	-3,861	WELLNESS CLINIC	194.01	0	33.42
33.43	NON ALLOWABLE LEGAL FEES	A	-44,469	OTHER A&G	5.03	0	33.43
33.44	NP BENEFITS	A	-30,096	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/23/2024 11:12 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,720,289				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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2024 11:12 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	2.00	CAP REL COSTS-MVBLE EQUIP	FITNESS CENTER - PROP INSURA	0	2,823	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	1,052	2.00
3.00	5.01	IS/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	3,785	3.00
4.00	5.03	OTHER A&G	FITNESS CENTER - ADMIN	0	3,967	4.00
4.01	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	2,508	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	882	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	15,017	5.00

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

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

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

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

6.00	C		0.00	JV PAIN CLINIC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2024 11:12 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	-2,823	11		1.00
2.00	-1,052	0		2.00
3.00	-3,785	0		3.00
4.00	-3,967	0		4.00
4.01	-2,508	0		4.01
4.02	-882	0		4.02
5.00	-15,017			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	JV PAIN CLINIC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2024 11:12 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	414,777	414,777	0	0	0	1.00
2.00	50.00	OPERATING ROOM	601,158	552,491	48,667	0	0	2.00
3.00	60.00	LABORATORY	36,000	0	36,000	0	0	3.00
4.00	90.00	CLINIC	16,377	16,377	0	0	0	4.00
5.00	90.01	PAIN MANAGEMENT	1,392,413	1,392,413	0	0	0	5.00
6.00	90.02	CLINIC - LAKESIDE	806,289	806,289	0	0	0	6.00
7.00	90.03	CLINIC - QUICKCARE	480,051	480,051	0	0	0	7.00
8.00	90.04	WOMENS HEALTH CLINIC	473,413	473,413	0	0	0	8.00
9.00	90.05	ORTHO CLINIC	146,248	134,248	12,000	0	0	9.00
10.00	91.00	EMERGENCY	1,469,304	0	1,469,304	0	0	10.00
11.00	93.00	BEHAVIOR HEALTH	453,100	402,735	50,365	0	0	11.00
12.00	5.03	OTHER A&G	186,527	186,527	0	0	0	12.00
200.00			6,475,657	4,859,321	1,616,336		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	PAIN MANAGEMENT	0	0	0	0	0	5.00
6.00	90.02	CLINIC - LAKESIDE	0	0	0	0	0	6.00
7.00	90.03	CLINIC - QUICKCARE	0	0	0	0	0	7.00
8.00	90.04	WOMENS HEALTH CLINIC	0	0	0	0	0	8.00
9.00	90.05	ORTHO CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	93.00	BEHAVIOR HEALTH	0	0	0	0	0	11.00
12.00	5.03	OTHER A&G	0	0	0	0	0	12.00
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	414,777		1.00
2.00	50.00	OPERATING ROOM	0	0	0	552,491		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	16,377		4.00
5.00	90.01	PAIN MANAGEMENT	0	0	0	1,392,413		5.00
6.00	90.02	CLINIC - LAKESIDE	0	0	0	806,289		6.00
7.00	90.03	CLINIC - QUICKCARE	0	0	0	480,051		7.00
8.00	90.04	WOMENS HEALTH CLINIC	0	0	0	473,413		8.00
9.00	90.05	ORTHO CLINIC	0	0	0	134,248		9.00
10.00	91.00	EMERGENCY	0	0	0	0		10.00
11.00	93.00	BEHAVIOR HEALTH	0	0	0	402,735		11.00
12.00	5.03	OTHER A&G	0	0	0	186,527		12.00
200.00			0	0	0	4,859,321		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	669,564	669,564				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,248,955		1,248,955			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,946,277	2,598	4,847	6,953,722		4.00
5.01	00590	IS/ACCOUNTING/MARKETING	1,588,313	7,994	14,911	230,579	1,841,797	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	1,685,577	34,438	64,239	389,617	2,173,871	5.02
5.03	00592	OTHER A&G	4,203,885	13,412	25,018	674,199	4,916,514	5.03
7.00	00700	OPERATION OF PLANT	1,459,448	58,034	108,252	152,764	1,778,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,801	3,947	7,363	21,570	125,681	8.00
9.00	00900	HOUSEKEEPING	614,551	2,038	3,801	178,291	798,681	9.00
10.00	01000	DIETARY	635,505	16,133	30,094	155,373	837,105	10.00
11.00	01100	CAFETERIA	0	11,766	21,947	0	33,713	11.00
13.00	01300	NURSING ADMINISTRATION	531,113	8,157	15,216	146,282	700,768	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	196,948	11,538	21,522	53,732	283,740	14.00
15.00	01500	PHARMACY	1,849,294	8,391	15,651	163,089	2,036,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	633,692	7,737	14,431	189,442	845,302	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,926,864	99,602	185,790	1,131,368	5,343,624	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	265,161	1,156	2,157	41,875	310,349	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,038,759	106,135	197,977	532,048	2,874,919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	127,859	2,628	4,901	20,192	155,580	52.00
53.00	05300	ANESTHESIOLOGY	2,364	2,423	4,520	0	9,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192,581	44,190	82,428	239,010	1,558,209	54.00
54.01	05401	ULTRASOUND	223,555	1,378	2,570	57,733	285,236	54.01
56.00	05600	RADIOISOTOPE	110,833	1,991	3,714	0	116,538	56.00
60.00	06000	LABORATORY	2,289,342	16,875	31,477	311,359	2,649,053	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	605,135	9,313	17,372	172,435	804,255	65.00
66.00	06600	PHYSICAL THERAPY	775,816	26,346	49,143	243,447	1,094,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,920	987	1,841	71,663	308,411	67.00
68.00	06800	SPEECH PATHOLOGY	97,339	852	1,590	29,627	129,408	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,810	969	1,808	0	6,587	70.00
70.01	07001	CARDIOPULMONARY	48,468	6,773	12,634	28,595	96,470	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,166,543	0	0	0	1,166,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	718,737	0	0	0	718,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-60,896	0	0	0	-60,896	73.00
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	2,301,184	0	0	577,089	2,878,273	88.00
90.00	09000	CLINIC	59,971	2,581	4,814	0	67,366	90.00
90.01	09001	PAIN MANAGEMENT	729,088	15,946	29,745	215,432	990,211	90.01
90.02	09002	CLINIC - LAKESIDE	500,297	26,276	49,012	80,307	655,892	90.02
90.03	09003	CLINIC - QUICKCARE	400,711	19,333	36,062	72,245	528,351	90.03
90.04	09004	WOMENS HEALTH CLINIC	217,997	16,483	30,747	31,721	296,948	90.04
90.05	09005	ORTHO CLINIC	164,357	3,579	6,677	42,462	217,075	90.05
91.00	09100	EMERGENCY	2,588,883	37,591	70,120	323,614	3,020,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	BEHAVIOR HEALTH	508,370	23,479	43,795	91,636	667,280	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,592,971	653,069	1,218,186	6,668,796	43,260,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,702	6,905	0	10,607	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,220	12,793	23,864	0	122,877	192.00
192.01	19201	MSO CLINICS	602,087	0	0	114,863	716,950	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	289,992	0	0	61,260	351,252	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	22,429	0	0	5,870	28,299	194.03
194.04	07954	TH PAIN	397,938	0	0	102,933	500,871	194.04
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/23/2024 11:12 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	44,991,637	669,564	1,248,955	6,953,722	44,991,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	IS/ACCOUNTING /MARKETING	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER A&G	
			5.01	5A.01	5.02	5A.02	5.03	
		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	00590	IS/ACCOUNTING/MARKETING	1,841,797					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	93,007	2,266,878	2,266,878			5.02
5.03	00592	OTHER A&G	210,348	5,126,862	0	5,126,862	5,126,862	5.03
7.00	00700	OPERATION OF PLANT	76,091	1,854,589	0	1,854,589	238,148	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,377	131,058	0	131,058	16,829	8.00
9.00	00900	HOUSEKEEPING	34,171	832,852	0	832,852	106,947	9.00
10.00	01000	DIETARY	35,815	872,920	0	872,920	112,092	10.00
11.00	01100	CAFETERIA	1,442	35,155	0	35,155	4,514	11.00
13.00	01300	NURSING ADMINISTRATION	29,982	730,750	0	730,750	93,836	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,140	295,880	20,857	316,737	40,672	14.00
15.00	01500	PHARMACY	87,126	2,123,551	149,691	2,273,242	291,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,165	881,467	0	881,467	113,189	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	228,613	5,572,237	392,808	5,965,045	765,979	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	13,278	323,627	22,813	346,440	44,486	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,001	2,997,920	211,326	3,209,246	412,099	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,656	162,236	11,436	173,672	22,301	52.00
53.00	05300	ANESTHESIOLOGY	398	9,705	684	10,389	1,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,666	1,624,875	114,539	1,739,414	223,358	54.00
54.01	05401	ULTRASOUND	12,204	297,440	20,967	318,407	40,887	54.01
56.00	05600	RADIOISOTOPE	4,986	121,524	8,566	130,090	16,705	56.00
60.00	06000	LABORATORY	113,337	2,762,390	194,724	2,957,114	379,723	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,409	838,664	59,118	897,782	115,284	65.00
66.00	06600	PHYSICAL THERAPY	46,838	1,141,590	80,472	1,222,062	156,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,195	321,606	22,670	344,276	44,208	67.00
68.00	06800	SPEECH PATHOLOGY	5,537	134,945	9,512	144,457	18,550	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	282	6,869	484	7,353	944	70.00
70.01	07001	CARDIOPULMONARY	4,127	100,597	7,091	107,688	13,828	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	49,909	1,216,452	85,749	1,302,201	167,216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,750	749,487	52,832	802,319	103,026	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	-60,896	0	-60,896	0	73.00
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	123,144	3,001,417	211,573	3,212,990	412,580	88.00
90.00	09000	CLINIC	2,882	70,248	4,952	75,200	9,656	90.00
90.01	09001	PAIN MANAGEMENT	42,365	1,032,576	72,787	1,105,363	141,940	90.01
90.02	09002	CLINIC - LAKESIDE	28,062	683,954	48,213	732,167	94,018	90.02
90.03	09003	CLINIC - QUICKCARE	22,605	550,956	38,837	589,793	75,735	90.03
90.04	09004	WOMENS HEALTH CLINIC	12,705	309,653	21,828	331,481	42,565	90.04
90.05	09005	ORTHO CLINIC	9,287	226,362	15,956	242,318	31,116	90.05
91.00	09100	EMERGENCY	129,217	3,149,425	222,006	3,371,431	432,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04950	BEHAVIOR HEALTH	28,549	695,829	49,050	744,879	95,650	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,774,666	43,193,650	2,151,541	43,078,313	4,881,172	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,607	0	10,607	1,362	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	122,877	0	122,877	15,779	192.00
192.01	19201	MSO CLINICS	30,674	747,624	52,701	800,325	102,770	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	15,028	366,280	25,819	392,099	50,349	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	28,299	0	28,299	3,634	194.03
194.04	07954	TH PAIN	21,429	522,300	36,817	559,117	71,796	194.04
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)	1,841,797	44,991,637	2,266,878	44,991,637	5,126,862	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT	2,092,737					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,935	162,822				8.00
9.00	00900	HOUSEKEEPING	7,711	29,906	977,416			9.00
10.00	01000	DIETARY	61,044	1,540	25,671	1,073,267		10.00
11.00	01100	CAFETERIA	44,518	1,799	18,721	742,981	847,688	11.00
13.00	01300	NURSING ADMINISTRATION	30,864	0	12,979	0	17,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,656	0	18,359	0	9,250	14.00
15.00	01500	PHARMACY	31,748	0	13,351	0	26,375	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,274	0	12,310	0	35,563	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	376,866	30,951	158,485	150,859	166,278	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	4,374	1,149	1,840	0	6,094	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	401,587	19,513	168,883	10,646	101,625	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,942	3,240	4,181	0	2,938	52.00
53.00	05300	ANESTHESIOLOGY	9,169	0	3,856	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,202	15,729	70,314	0	48,906	54.00
54.01	05401	ULTRASOUND	5,214	0	2,193	0	15,625	54.01
56.00	05600	RADIOISOTOPE	7,534	0	3,168	0	0	56.00
60.00	06000	LABORATORY	63,849	0	26,851	0	72,781	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,239	4,186	14,819	0	33,500	65.00
66.00	06600	PHYSICAL THERAPY	99,685	9,668	41,921	0	31,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,734	0	1,570	0	7,969	67.00
68.00	06800	SPEECH PATHOLOGY	3,226	0	1,356	0	3,375	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,667	0	1,542	0	0	70.00
70.01	07001	CARDIOPULMONARY	25,628	0	10,777	0	3,188	70.01
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
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	106,874	0	50,000	88.00
90.00	09000	CLINIC	9,765	0	4,107	0	594	90.00
90.01	09001	PAIN MANAGEMENT	60,337	15,622	25,374	0	29,844	90.01
90.02	09002	CLINIC - LAKESIDE	99,420	0	41,809	0	24,594	90.02
90.03	09003	CLINIC - QUICKCARE	73,151	0	30,762	0	28,656	90.03
90.04	09004	WOMENS HEALTH CLINIC	62,369	0	26,228	0	11,063	90.04
90.05	09005	ORTHO CLINIC	13,543	0	5,695	0	10,719	90.05
91.00	09100	EMERGENCY	142,236	29,519	59,815	11,312	57,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	88,837	0	37,359	0	13,156	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,030,324	162,822	951,170	915,798	807,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,007	0	5,890	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,406	0	20,356	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	17,750	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	157,469	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	0	13,969	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0	688	194.03
194.04	07954	TH PAIN	0	0	0	0	7,969	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,092,737	162,822	977,416	1,073,267	847,688	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	885,460					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	428,674				14.00
15.00	01500	PHARMACY	0	4,240	2,640,863			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14	0	1,071,817		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	399,505	3,031	0	50,618	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	14,629	191	0	1,758	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,737	26,421	0	97,608	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,053	92	0	4,957	0	52.00
53.00	05300	ANESTHESIOLOGY	0	616	0	12,679	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,470	0	176,635	0	54.00
54.01	05401	ULTRASOUND	0	982	0	32,742	0	54.01
56.00	05600	RADIOISOTOPE	0	505	0	7,106	0	56.00
60.00	06000	LABORATORY	0	26,250	0	197,497	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,822	0	15,354	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,034	0	21,390	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25	0	7,143	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	40	0	1,481	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	417	0	70.00
70.01	07001	CARDIOPULMONARY	7,641	285	0	2,225	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	213,430	0	115,580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	129,590	0	10,518	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,640,863	87,112	0	73.00
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	1,683	0	33,320	0	88.00
90.00	09000	CLINIC	1,433	5	0	1,176	0	90.00
90.01	09001	PAIN MANAGEMENT	71,666	1,397	0	17,537	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	1,243	0	30,364	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	1,124	0	32,626	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	728	0	5,544	0	90.04
90.05	09005	ORTHO CLINIC	0	296	0	5,347	0	90.05
91.00	09100	EMERGENCY	137,065	1,233	0	91,915	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	11,594	2,305	0	11,168	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	866,323	427,052	2,640,863	1,071,817	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140	0	0	0	192.00
192.01	19201	MSO CLINICS	0	564	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	918	0	0	0	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0	0	194.03
194.04	07954	TH PAIN	19,137	0	0	0	0	194.04
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)	885,460	428,674	2,640,863	1,071,817	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	IS/ACCOUNTING/MARKETING					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING					5.02
5.03	00592	OTHER A&G					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,067,617	0	8,067,617		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	420,961	0	420,961		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,663,365	0	4,663,365		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,376	0	228,376		52.00
53.00	05300	ANESTHESIOLOGY	38,043	0	38,043		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,445,028	0	2,445,028		54.00
54.01	05401	ULTRASOUND	416,050	0	416,050		54.01
56.00	05600	RADIOISOTOPE	165,108	0	165,108		56.00
60.00	06000	LABORATORY	3,724,065	0	3,724,065		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,122,986	0	1,122,986		65.00
66.00	06600	PHYSICAL THERAPY	1,583,810	0	1,583,810		66.00
67.00	06700	OCCUPATIONAL THERAPY	408,925	0	408,925		67.00
68.00	06800	SPEECH PATHOLOGY	172,485	0	172,485		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,923	0	13,923		70.00
70.01	07001	CARDIOPULMONARY	171,260	0	171,260		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,798,427	0	1,798,427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,045,453	0	1,045,453		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,667,079	0	2,667,079		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,817,447	0	3,817,447		88.00
90.00	09000	CLINIC	101,936	0	101,936		90.00
90.01	09001	PAIN MANAGEMENT	1,469,080	0	1,469,080		90.01
90.02	09002	CLINIC - LAKESIDE	1,023,615	0	1,023,615		90.02
90.03	09003	CLINIC - QUICKCARE	831,847	0	831,847		90.03
90.04	09004	WOMENS HEALTH CLINIC	479,978	0	479,978		90.04
90.05	09005	ORTHO CLINIC	309,034	0	309,034		90.05
91.00	09100	EMERGENCY	4,334,514	0	4,334,514		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04950	BEHAVIOR HEALTH	1,004,948	0	1,004,948		93.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,525,360	0	42,525,360		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,866	0	31,866		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	207,558	0	207,558		192.00
192.01	19201	MSO CLINICS	921,409	0	921,409		192.01
192.03	19203	FPA	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	157,469	0	157,469		194.00
194.01	07951	WELLNESS CLINIC	457,335	0	457,335		194.01
194.02	07952	OTHER (SPECIFY)	0	0	0		194.02
194.03	07953	NONREIMBURSABLE - OTHER	32,621	0	32,621		194.03
194.04	07954	TH PAIN	658,019	0	658,019		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	44,991,637	0	44,991,637		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/23/2024 11:12 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	2,598	4,847	7,445	7,445	4.00
5.01	00590	IS/ACCOUNTING/MARKETING	0	7,994	14,911	22,905	247	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	0	34,438	64,239	98,677	417	5.02
5.03	00592	OTHER A&G	0	13,412	25,018	38,430	721	5.03
7.00	00700	OPERATION OF PLANT	0	58,034	108,252	166,286	163	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,947	7,363	11,310	23	8.00
9.00	00900	HOUSEKEEPING	0	2,038	3,801	5,839	191	9.00
10.00	01000	DIETARY	0	16,133	30,094	46,227	166	10.00
11.00	01100	CAFETERIA	0	11,766	21,947	33,713	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,157	15,216	23,373	157	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,538	21,522	33,060	57	14.00
15.00	01500	PHARMACY	0	8,391	15,651	24,042	174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,737	14,431	22,168	203	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	99,602	185,790	285,392	1,217	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,156	2,157	3,313	45	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	106,135	197,977	304,112	569	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,628	4,901	7,529	22	52.00
53.00	05300	ANESTHESIOLOGY	0	2,423	4,520	6,943	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,190	82,428	126,618	256	54.00
54.01	05401	ULTRASOUND	0	1,378	2,570	3,948	62	54.01
56.00	05600	RADIOISOTOPE	0	1,991	3,714	5,705	0	56.00
60.00	06000	LABORATORY	0	16,875	31,477	48,352	333	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,313	17,372	26,685	184	65.00
66.00	06600	PHYSICAL THERAPY	0	26,346	49,143	75,489	260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	987	1,841	2,828	77	67.00
68.00	06800	SPEECH PATHOLOGY	0	852	1,590	2,442	32	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	969	1,808	2,777	0	70.00
70.01	07001	CARDIOPULMONARY	0	6,773	12,634	19,407	31	70.01
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
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	617	88.00
90.00	09000	CLINIC	0	2,581	4,814	7,395	0	90.00
90.01	09001	PAIN MANAGEMENT	0	15,946	29,745	45,691	230	90.01
90.02	09002	CLINIC - LAKESIDE	0	26,276	49,012	75,288	86	90.02
90.03	09003	CLINIC - QUICKCARE	0	19,333	36,062	55,395	77	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	16,483	30,747	47,230	34	90.04
90.05	09005	ORTHO CLINIC	0	3,579	6,677	10,256	45	90.05
91.00	09100	EMERGENCY	0	37,591	70,120	107,711	346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	BEHAVIOR HEALTH	0	23,479	43,795	67,274	98	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	653,069	1,218,186	1,871,255	7,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,702	6,905	10,607	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,793	23,864	36,657	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	123	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	0	66	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0	6	194.03
194.04	07954	TH PAIN	0	0	0	0	110	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/23/2024 11:12 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	0	669,564	1,248,955	1,918,519	7,445	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	IS/ACCOUNTING /MARKETING	BUSINESS OFFICE & ADMITTING	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	00590	IS/ACCOUNTING/MARKETING	23,152					5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	1,170	100,264				5.02
5.03	00592	OTHER A&G	2,645	0	41,796			5.03
7.00	00700	OPERATION OF PLANT	957	0	1,942	169,348		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68	0	137	1,209	12,747	8.00
9.00	00900	HOUSEKEEPING	430	0	872	624	2,341	9.00
10.00	01000	DIETARY	450	0	914	4,940	121	10.00
11.00	01100	CAFETERIA	18	0	37	3,602	141	11.00
13.00	01300	NURSING ADMINISTRATION	377	0	765	2,498	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153	923	332	3,533	0	14.00
15.00	01500	PHARMACY	1,096	6,621	2,380	2,569	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	455	0	923	2,369	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,862	17,368	6,238	30,497	2,422	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	167	1,009	363	354	90	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,547	9,348	3,360	32,495	1,528	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84	506	182	805	254	52.00
53.00	05300	ANESTHESIOLOGY	5	30	11	742	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	838	5,066	1,821	13,530	1,231	54.00
54.01	05401	ULTRASOUND	153	927	333	422	0	54.01
56.00	05600	RADIOISOTOPE	63	379	136	610	0	56.00
60.00	06000	LABORATORY	1,425	8,613	3,096	5,167	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	433	2,615	940	2,852	328	65.00
66.00	06600	PHYSICAL THERAPY	589	3,559	1,279	8,067	757	66.00
67.00	06700	OCCUPATIONAL THERAPY	166	1,003	360	302	0	67.00
68.00	06800	SPEECH PATHOLOGY	70	421	151	261	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4	21	8	297	0	70.00
70.01	07001	CARDIOPULMONARY	52	314	113	2,074	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	628	3,793	1,363	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	387	2,337	840	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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	1,549	9,358	3,364	0	0	88.00
90.00	09000	CLINIC	36	219	79	790	0	90.00
90.01	09001	PAIN MANAGEMENT	533	3,220	1,157	4,883	1,223	90.01
90.02	09002	CLINIC - LAKESIDE	353	2,133	767	8,045	0	90.02
90.03	09003	CLINIC - QUICKCARE	284	1,718	618	5,919	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	160	965	347	5,047	0	90.04
90.05	09005	ORTHO CLINIC	117	706	254	1,096	0	90.05
91.00	09100	EMERGENCY	1,625	9,820	3,530	11,510	2,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	359	2,170	780	7,189	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,308	95,162	39,792	164,298	12,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11	1,133	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	129	3,917	0	192.00
192.01	19201	MSO CLINICS	386	2,331	838	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	189	1,142	411	0	0	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	30	0	0	194.03
194.04	07954	TH PAIN	269	1,629	585	0	0	194.04
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)	23,152	100,264	41,796	169,348	12,747	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			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	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	10,297					9.00
10.00	01000	DIETARY	270	53,088				10.00
11.00	01100	CAFETERIA	197	36,750	74,458			11.00
13.00	01300	NURSING ADMINISTRATION	137	0	1,496	28,803		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	193	0	812	0	39,063	14.00
15.00	01500	PHARMACY	141	0	2,317	0	386	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130	0	3,124	0	1	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,670	7,462	14,607	12,994	276	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	19	0	535	476	17	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,780	527	8,926	7,018	2,408	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44	0	258	229	8	52.00
53.00	05300	ANESTHESIOLOGY	41	0	0	0	56	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	741	0	4,296	0	316	54.00
54.01	05401	ULTRASOUND	23	0	1,372	0	90	54.01
56.00	05600	RADIOISOTOPE	33	0	0	0	46	56.00
60.00	06000	LABORATORY	283	0	6,393	0	2,392	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	156	0	2,943	0	622	65.00
66.00	06600	PHYSICAL THERAPY	442	0	2,734	0	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	0	700	0	2	67.00
68.00	06800	SPEECH PATHOLOGY	14	0	296	0	4	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	114	0	280	249	26	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	19,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,809	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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	1,126	0	4,392	0	153	88.00
90.00	09000	CLINIC	43	0	52	47	0	90.00
90.01	09001	PAIN MANAGEMENT	267	0	2,621	2,331	127	90.01
90.02	09002	CLINIC - LAKESIDE	440	0	2,160	0	113	90.02
90.03	09003	CLINIC - QUICKCARE	324	0	2,517	0	102	90.03
90.04	09004	WOMENS HEALTH CLINIC	276	0	972	0	66	90.04
90.05	09005	ORTHO CLINIC	60	0	941	0	27	90.05
91.00	09100	EMERGENCY	630	560	5,012	4,459	112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	394	0	1,156	377	210	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,021	45,299	70,912	28,180	38,915	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	62	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	214	0	0	0	13	192.00
192.01	19201	MSO CLINICS	0	0	1,559	0	51	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	7,789	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	1,227	0	84	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	60	0	0	194.03
194.04	07954	TH PAIN	0	0	700	623	0	194.04
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)	10,297	53,088	74,458	28,803	39,063	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	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	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	39,726					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,373				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,388		384,393	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00	04300	NURSERY	0	48		6,436	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,676		376,294	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	136		10,057	0	52.00
53.00	05300	ANESTHESIOLOGY	0	348		8,176	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,843		159,556	0	54.00
54.01	05401	ULTRASOUND	0	898		8,228	0	54.01
56.00	05600	RADIOISOTOPE	0	195		7,167	0	56.00
60.00	06000	LABORATORY	0	5,400		81,454	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	421		38,179	0	65.00
66.00	06600	PHYSICAL THERAPY	0	586		93,856	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	196		5,651	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	41		3,732	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11		3,134	0	70.00
70.01	07001	CARDIOPULMONARY	0	61		22,721	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,169		28,405	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	288		15,661	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,726	2,388		42,114	0	73.00
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	0	914		21,473	0	88.00
90.00	09000	CLINIC	0	32		8,693	0	90.00
90.01	09001	PAIN MANAGEMENT	0	481		62,764	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	833		90,218	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	895		67,849	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	152		55,249	0	90.04
90.05	09005	ORTHO CLINIC	0	147		13,649	0	90.05
91.00	09100	EMERGENCY	0	2,520		150,146	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	BEHAVIOR HEALTH	0	306		80,313	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,726	29,373	0	1,845,568	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		11,813	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		40,930	0	192.00
192.01	19201	MSO CLINICS	0	0		5,288	0	192.01
192.03	19203	FPA	0	0		0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0		7,789	0	194.00
194.01	07951	WELLNESS CLINIC	0	0		3,119	0	194.01
194.02	07952	OTHER (SPECIFY)	0	0		0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0		96	0	194.03
194.04	07954	TH PAIN	0	0		3,916	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,726	29,373	0	1,918,519	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/23/2024 11:12 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	00590	IS/ACCOUNTING/MARKETING			5.01
5.02	00591	BUSINESS OFFICE & ADMITTING			5.02
5.03	00592	OTHER A&G			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	384,393		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	6,436		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	376,294		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,057		52.00
53.00	05300	ANESTHESIOLOGY	8,176		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,556		54.00
54.01	05401	ULTRASOUND	8,228		54.01
56.00	05600	RADIOISOTOPE	7,167		56.00
60.00	06000	LABORATORY	81,454		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	38,179		65.00
66.00	06600	PHYSICAL THERAPY	93,856		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,651		67.00
68.00	06800	SPEECH PATHOLOGY	3,732		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,134		70.00
70.01	07001	CARDIOPULMONARY	22,721		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,405		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,661		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,114		73.00
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	21,473		88.00
90.00	09000	CLINIC	8,693		90.00
90.01	09001	PAIN MANAGEMENT	62,764		90.01
90.02	09002	CLINIC - LAKESIDE	90,218		90.02
90.03	09003	CLINIC - QUICKCARE	67,849		90.03
90.04	09004	WOMENS HEALTH CLINIC	55,249		90.04
90.05	09005	ORTHO CLINIC	13,649		90.05
91.00	09100	EMERGENCY	150,146		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	BEHAVIOR HEALTH	80,313		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,845,568		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,813		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,930		192.00
192.01	19201	MSO CLINICS	5,288		192.01
192.03	19203	FPA	0		192.03
194.00	07950	MEALS ON WHEELS	7,789		194.00
194.01	07951	WELLNESS CLINIC	3,119		194.01
194.02	07952	OTHER (SPECIFY)	0		194.02
194.03	07953	NONREIMBURSABLE - OTHER	96		194.03
194.04	07954	TH PAIN	3,916		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,918,519		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	IS/ACCOUNTING /MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	114,671					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		114,671				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	445	445	22,409,159			4.00
5.01	00590	IS/ACCOUNTING/MARKETING	1,369	1,369	743,068	-1,841,797	43,048,953	5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	5,898	5,898	1,255,585	0	2,173,871	5.02
5.03	00592	OTHER A&G	2,297	2,297	2,172,685	0	4,916,514	5.03
7.00	00700	OPERATION OF PLANT	9,939	9,939	492,298	0	1,778,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	676	69,511	0	125,681	8.00
9.00	00900	HOUSEKEEPING	349	349	574,562	0	798,681	9.00
10.00	01000	DIETARY	2,763	2,763	500,708	0	837,105	10.00
11.00	01100	CAFETERIA	2,015	2,015	0	0	33,713	11.00
13.00	01300	NURSING ADMINISTRATION	1,397	1,397	471,412	0	700,768	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,976	1,976	173,156	0	283,740	14.00
15.00	01500	PHARMACY	1,437	1,437	525,573	0	2,036,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,325	1,325	610,498	0	845,302	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,058	17,058	3,645,959	0	5,343,624	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	198	198	134,948	0	310,349	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,177	18,177	1,714,587	0	2,874,919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	450	450	65,071	0	155,580	52.00
53.00	05300	ANESTHESIOLOGY	415	415	0	0	9,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,568	7,568	770,238	0	1,558,209	54.00
54.01	05401	ULTRASOUND	236	236	186,052	0	285,236	54.01
56.00	05600	RADIOISOTOPE	341	341	0	0	116,538	56.00
60.00	06000	LABORATORY	2,890	2,890	1,003,389	0	2,649,053	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,595	1,595	555,692	0	804,255	65.00
66.00	06600	PHYSICAL THERAPY	4,512	4,512	784,535	0	1,094,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	169	169	230,941	0	308,411	67.00
68.00	06800	SPEECH PATHOLOGY	146	146	95,476	0	129,408	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166	166	0	0	6,587	70.00
70.01	07001	CARDIOPULMONARY	1,160	1,160	92,152	0	96,470	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,166,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	718,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,896	0	73.00
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	1,859,736	0	2,878,273	88.00
90.00	09000	CLINIC	442	442	0	0	67,366	90.00
90.01	09001	PAIN MANAGEMENT	2,731	2,731	694,255	0	990,211	90.01
90.02	09002	CLINIC - LAKESIDE	4,500	4,500	258,798	0	655,892	90.02
90.03	09003	CLINIC - QUICKCARE	3,311	3,311	232,817	0	528,351	90.03
90.04	09004	WOMENS HEALTH CLINIC	2,823	2,823	102,225	0	296,948	90.04
90.05	09005	ORTHO CLINIC	613	613	136,839	0	217,075	90.05
91.00	09100	EMERGENCY	6,438	6,438	1,042,882	0	3,020,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	4,021	4,021	295,306	0	667,280	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,846	111,846	21,490,954	-1,780,901	41,479,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	634	634	0	-10,607	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,191	2,191	0	-122,877	0	192.00
192.01	19201	MSO CLINICS	0	0	370,159	0	716,950	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	197,417	0	351,252	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	18,916	-28,299	0	194.03
194.04	07954	TH PAIN	0	0	331,713	0	500,871	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	IS/ACCOUNTING /MARKETING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
202.00		Cost to be allocated (per Wkst. B, Part I)	669,564	1,248,955	6,953,722		1,841,797	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.839000	10.891638	0.310307		0.042784	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,445		23,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000332		0.000538	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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	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	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING	-2,266,878	32,158,219				5.02
5.03	00592	OTHER A&G	-5,126,862	0	-5,126,862	39,925,671		5.03
7.00	00700	OPERATION OF PLANT	-1,854,589	0	0	1,854,589	94,723	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-131,058	0	0	131,058	676	8.00
9.00	00900	HOUSEKEEPING	-832,852	0	0	832,852	349	9.00
10.00	01000	DIETARY	-872,920	0	0	872,920	2,763	10.00
11.00	01100	CAFETERIA	-35,155	0	0	35,155	2,015	11.00
13.00	01300	NURSING ADMINISTRATION	-730,750	0	0	730,750	1,397	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	295,880	0	316,737	1,976	14.00
15.00	01500	PHARMACY	0	2,123,551	0	2,273,242	1,437	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-881,467	0	0	881,467	1,325	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,572,237	0	5,965,045	17,058	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	323,627	0	346,440	198	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,997,920	0	3,209,246	18,177	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	162,236	0	173,672	450	52.00
53.00	05300	ANESTHESIOLOGY	0	9,705	0	10,389	415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,624,875	0	1,739,414	7,568	54.00
54.01	05401	ULTRASOUND	0	297,440	0	318,407	236	54.01
56.00	05600	RADIOISOTOPE	0	121,524	0	130,090	341	56.00
60.00	06000	LABORATORY	0	2,762,390	0	2,957,114	2,890	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	838,664	0	897,782	1,595	65.00
66.00	06600	PHYSICAL THERAPY	0	1,141,590	0	1,222,062	4,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	321,606	0	344,276	169	67.00
68.00	06800	SPEECH PATHOLOGY	0	134,945	0	144,457	146	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,869	0	7,353	166	70.00
70.01	07001	CARDIOPULMONARY	0	100,597	0	107,688	1,160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,216,452	0	1,302,201	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	749,487	0	802,319	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,896	0	60,896	0	0	73.00
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	3,001,417	0	3,212,990	0	88.00
90.00	09000	CLINIC	0	70,248	0	75,200	442	90.00
90.01	09001	PAIN MANAGEMENT	0	1,032,576	0	1,105,363	2,731	90.01
90.02	09002	CLINIC - LAKESIDE	0	683,954	0	732,167	4,500	90.02
90.03	09003	CLINIC - QUICKCARE	0	550,956	0	589,793	3,311	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	309,653	0	331,481	2,823	90.04
90.05	09005	ORTHO CLINIC	0	226,362	0	242,318	613	90.05
91.00	09100	EMERGENCY	0	3,149,425	0	3,371,431	6,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	0	695,829	0	744,879	4,021	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,671,635	30,522,015	-5,065,966	38,012,347	91,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-10,607	0	0	10,607	634	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-122,877	0	0	122,877	2,191	192.00
192.01	19201	MSO CLINICS	0	747,624	0	800,325	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	366,280	0	392,099	0	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	-28,299	0	0	28,299	0	194.03
194.04	07954	TH PAIN	0	522,300	0	559,117	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		2,266,878		5,126,862	2,092,737	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

	Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	7.00	
203.00	Unit cost multiplier (Wkst. B, Part I)		0.070491		0.128410	22.093230	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		100,264		41,796	169,348	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.003118		0.001047	1.787823	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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEE T HKG)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (DIRECT NRS ING HR)	
			8.00	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	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	168,118					8.00
9.00	00900	HOUSEKEEPING	30,879	105,201				9.00
10.00	01000	DIETARY	1,590	2,763	59,583			10.00
11.00	01100	CAFETERIA	1,858	2,015	41,247	27,126		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,397	0	545	245,317	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,976	0	296	0	14.00
15.00	01500	PHARMACY	0	1,437	0	844	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,325	0	1,138	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,958	17,058	8,375	5,321	110,683	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,186	198	0	195	4,053	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,148	18,177	591	3,252	59,770	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,345	450	0	94	1,954	52.00
53.00	05300	ANESTHESIOLOGY	0	415	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,241	7,568	0	1,565	0	54.00
54.01	05401	ULTRASOUND	0	236	0	500	0	54.01
56.00	05600	RADIOISOTOPE	0	341	0	0	0	56.00
60.00	06000	LABORATORY	0	2,890	0	2,329	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,322	1,595	0	1,072	0	65.00
66.00	06600	PHYSICAL THERAPY	9,982	4,512	0	996	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	169	0	255	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	146	0	108	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	166	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,160	0	102	2,117	70.01
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
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	11,503	0	1,600	0	88.00
90.00	09000	CLINIC	0	442	0	19	397	90.00
90.01	09001	PAIN MANAGEMENT	16,130	2,731	0	955	19,855	90.01
90.02	09002	CLINIC - LAKESIDE	0	4,500	0	787	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	3,311	0	917	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	2,823	0	354	0	90.04
90.05	09005	ORTHO CLINIC	0	613	0	343	0	90.05
91.00	09100	EMERGENCY	30,479	6,438	628	1,826	37,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	0	4,021	0	421	3,212	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,118	102,376	50,841	25,834	240,015	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	634	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,191	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	568	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	8,742	0	0	194.00
194.01	07951	WELLNESS CLINIC	0	0	0	447	0	194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0	0	194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	22	0	194.03
194.04	07954	TH PAIN	0	0	0	255	5,302	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEE T HKG)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (DIRECT NRS ING HR)	
			8.00	9.00	10.00	11.00	13.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	162,822	977,416	1,073,267	847,688	885,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.968498	9.290938	18.012973	31.250018	3.609452	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,747	10,297	53,088	74,458	28,803	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.075822	0.097879	0.890992	2.744894	0.117411	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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	IS/ACCOUNTING/MARKETING						5.01
5.02	00591	BUSINESS OFFICE & ADMITTING						5.02
5.03	00592	OTHER A&G						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,377,517					14.00
15.00	01500	PHARMACY	23,517	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80	0	147,680,472			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,813	0	6,974,136	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	1,058	0	242,178	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,539	0	13,448,269	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	511	0	682,998	0		52.00
53.00	05300	ANESTHESIOLOGY	3,417	0	1,746,845	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,244	0	24,336,651	0		54.00
54.01	05401	ULTRASOUND	5,448	0	4,511,120	0		54.01
56.00	05600	RADIOISOTOPE	2,802	0	979,101	0		56.00
60.00	06000	LABORATORY	145,589	0	27,217,502	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	37,838	0	2,115,390	0		65.00
66.00	06600	PHYSICAL THERAPY	5,737	0	2,947,113	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	138	0	984,172	0		67.00
68.00	06800	SPEECH PATHOLOGY	224	0	204,098	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	57,505	0		70.00
70.01	07001	CARDIOPULMONARY	1,579	0	306,550	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,183,709	0	15,924,518	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	718,737	0	1,449,123	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	12,002,141	0		73.00
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	9,334	0	4,590,825	0		88.00
90.00	09000	CLINIC	26	0	161,971	0		90.00
90.01	09001	PAIN MANAGEMENT	7,749	0	2,416,247	0		90.01
90.02	09002	CLINIC - LAKESIDE	6,893	0	4,183,562	0		90.02
90.03	09003	CLINIC - QUICKCARE	6,234	0	4,495,166	0		90.03
90.04	09004	WOMENS HEALTH CLINIC	4,039	0	763,803	0		90.04
90.05	09005	ORTHO CLINIC	1,644	0	736,735	0		90.05
91.00	09100	EMERGENCY	6,839	0	12,664,010	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	BEHAVIOR HEALTH	12,785	0	1,538,743	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,368,523	100	147,680,472	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	776	0	0	0		192.00
192.01	19201	MSO CLINICS	3,126	0	0	0		192.01
192.03	19203	FPA	0	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0		194.00
194.01	07951	WELLNESS CLINIC	5,092	0	0	0		194.01
194.02	07952	OTHER (SPECIFY)	0	0	0	0		194.02
194.03	07953	NONREIMBURSABLE - OTHER	0	0	0	0		194.03
194.04	07954	TH PAIN	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 11:12 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	428,674	2,640,863	1,071,817	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.180303	26,408.630000	0.007258	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,063	39,726	29,373	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016430	397.260000	0.000199	0.000000		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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,067,617		8,067,617	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	420,961		420,961	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,663,365		4,663,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,376		228,376	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,043		38,043	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,445,028		2,445,028	0	0	54.00
54.01	05401	ULTRASOUND	416,050		416,050	0	0	54.01
56.00	05600	RADIOISOTOPE	165,108		165,108	0	0	56.00
60.00	06000	LABORATORY	3,724,065		3,724,065	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,122,986	0	1,122,986	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,583,810	0	1,583,810	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	408,925	0	408,925	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	172,485	0	172,485	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,923		13,923	0	0	70.00
70.01	07001	CARDIOPULMONARY	171,260		171,260	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,798,427		1,798,427	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,045,453		1,045,453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,667,079		2,667,079	0	0	73.00
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	3,817,447		3,817,447	0	0	88.00
90.00	09000	CLINIC	101,936		101,936	0	0	90.00
90.01	09001	PAIN MANAGEMENT	1,469,080		1,469,080	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	1,023,615		1,023,615	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	831,847		831,847	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	479,978		479,978	0	0	90.04
90.05	09005	ORTHO CLINIC	309,034		309,034	0	0	90.05
91.00	09100	EMERGENCY	4,334,514		4,334,514	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,356,796		4,356,796		0	92.00
93.00	04950	BEHAVIOR HEALTH	1,004,948		1,004,948	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	46,882,156	0	46,882,156	0	0	200.00
201.00		Less Observation Beds	4,356,796		4,356,796		0	201.00
202.00		Total (see instructions)	42,525,360	0	42,525,360	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 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	2,718,937		2,718,937			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	242,178		242,178			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	769,297	12,678,972	13,448,269	0.346763	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	499,260	183,738	682,998	0.334373	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	200,720	1,546,125	1,746,845	0.021778	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,845	23,800,806	24,336,651	0.100467	0.000000	54.00
54.01	05401	ULTRASOUND	151,813	4,359,307	4,511,120	0.092228	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,117	972,984	979,101	0.168632	0.000000	56.00
60.00	06000	LABORATORY	1,408,941	25,808,561	27,217,502	0.136826	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	289,203	1,826,187	2,115,390	0.530865	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	66,175	2,880,938	2,947,113	0.537411	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,930	965,242	984,172	0.415502	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,405	198,693	204,098	0.845109	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,085	56,420	57,505	0.242118	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	306,550	306,550	0.558669	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,959,714	13,964,804	15,924,518	0.112934	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	164,750	1,284,373	1,449,123	0.721438	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	948,863	11,053,278	12,002,141	0.222217	0.000000	73.00
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	4,590,825	4,590,825			88.00
90.00	09000	CLINIC	0	161,971	161,971	0.629347	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	785	2,415,462	2,416,247	0.608001	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	4,183,562	4,183,562	0.244675	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	4,495,166	4,495,166	0.185054	0.000000	90.03
90.04	09004	WOMENS HEALTH CLINIC	1,487	762,316	763,803	0.628405	0.000000	90.04
90.05	09005	ORTHO CLINIC	229	736,506	736,735	0.419464	0.000000	90.05
91.00	09100	EMERGENCY	203,473	12,460,537	12,664,010	0.342270	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	192,778	4,062,421	4,255,199	1.023876	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	100,524	1,438,219	1,538,743	0.653097	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	10,486,509	137,193,963	147,680,472			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,486,509	137,193,963	147,680,472			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
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
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0.000000	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.000000	90.04
90.05	09005	ORTHO CLINIC	0.000000	90.05
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,067,617		8,067,617	0	8,067,617	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	420,961		420,961	0	420,961	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,663,365		4,663,365	0	4,663,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,376		228,376	0	228,376	52.00
53.00	05300	ANESTHESIOLOGY	38,043		38,043	0	38,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,445,028		2,445,028	0	2,445,028	54.00
54.01	05401	ULTRASOUND	416,050		416,050	0	416,050	54.01
56.00	05600	RADIOISOTOPE	165,108		165,108	0	165,108	56.00
60.00	06000	LABORATORY	3,724,065		3,724,065	0	3,724,065	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,122,986	0	1,122,986	0	1,122,986	65.00
66.00	06600	PHYSICAL THERAPY	1,583,810	0	1,583,810	0	1,583,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	408,925	0	408,925	0	408,925	67.00
68.00	06800	SPEECH PATHOLOGY	172,485	0	172,485	0	172,485	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,923		13,923	0	13,923	70.00
70.01	07001	CARDIOPULMONARY	171,260		171,260	0	171,260	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,798,427		1,798,427	0	1,798,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,045,453		1,045,453	0	1,045,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,667,079		2,667,079	0	2,667,079	73.00
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	3,817,447		3,817,447	0	3,817,447	88.00
90.00	09000	CLINIC	101,936		101,936	0	101,936	90.00
90.01	09001	PAIN MANAGEMENT	1,469,080		1,469,080	0	1,469,080	90.01
90.02	09002	CLINIC - LAKESIDE	1,023,615		1,023,615	0	1,023,615	90.02
90.03	09003	CLINIC - QUICKCARE	831,847		831,847	0	831,847	90.03
90.04	09004	WOMENS HEALTH CLINIC	479,978		479,978	0	479,978	90.04
90.05	09005	ORTHO CLINIC	309,034		309,034	0	309,034	90.05
91.00	09100	EMERGENCY	4,334,514		4,334,514	0	4,334,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,356,796		4,356,796		4,356,796	92.00
93.00	04950	BEHAVIOR HEALTH	1,004,948		1,004,948	0	1,004,948	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	46,882,156	0	46,882,156	0	46,882,156	200.00
201.00		Less Observation Beds	4,356,796		4,356,796		4,356,796	201.00
202.00		Total (see instructions)	42,525,360	0	42,525,360	0	42,525,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 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	2,718,937		2,718,937			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	242,178		242,178			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	769,297	12,678,972	13,448,269	0.346763	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	499,260	183,738	682,998	0.334373	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	200,720	1,546,125	1,746,845	0.021778	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,845	23,800,806	24,336,651	0.100467	0.000000	54.00
54.01	05401	ULTRASOUND	151,813	4,359,307	4,511,120	0.092228	0.000000	54.01
56.00	05600	RADIOISOTOPE	6,117	972,984	979,101	0.168632	0.000000	56.00
60.00	06000	LABORATORY	1,408,941	25,808,561	27,217,502	0.136826	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	289,203	1,826,187	2,115,390	0.530865	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	66,175	2,880,938	2,947,113	0.537411	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,930	965,242	984,172	0.415502	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,405	198,693	204,098	0.845109	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,085	56,420	57,505	0.242118	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	306,550	306,550	0.558669	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,959,714	13,964,804	15,924,518	0.112934	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	164,750	1,284,373	1,449,123	0.721438	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	948,863	11,053,278	12,002,141	0.222217	0.000000	73.00
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	4,590,825	4,590,825	0.831538	0.000000	88.00
90.00	09000	CLINIC	0	161,971	161,971	0.629347	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	785	2,415,462	2,416,247	0.608001	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	4,183,562	4,183,562	0.244675	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	4,495,166	4,495,166	0.185054	0.000000	90.03
90.04	09004	WOMENS HEALTH CLINIC	1,487	762,316	763,803	0.628405	0.000000	90.04
90.05	09005	ORTHO CLINIC	229	736,506	736,735	0.419464	0.000000	90.05
91.00	09100	EMERGENCY	203,473	12,460,537	12,664,010	0.342270	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	192,778	4,062,421	4,255,199	1.023876	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	100,524	1,438,219	1,538,743	0.653097	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	10,486,509	137,193,963	147,680,472			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,486,509	137,193,963	147,680,472			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 11:12 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	CARDIOPULMONARY	0.000000		70.01
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
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
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
90.02	09002	CLINIC - LAKESIDE	0.000000		90.02
90.03	09003	CLINIC - QUICKCARE	0.000000		90.03
90.04	09004	WOMENS HEALTH CLINIC	0.000000		90.04
90.05	09005	ORTHO CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	BEHAVIOR HEALTH	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/23/2024 11:12 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	376,294	13,448,269	0.027981	165,034	4,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,057	682,998	0.014725	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,176	1,746,845	0.004680	26,899	126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,556	24,336,651	0.006556	186,153	1,220	54.00
54.01	05401	ULTRASOUND	8,228	4,511,120	0.001824	78,893	144	54.01
56.00	05600	RADIOISOTOPE	7,167	979,101	0.007320	0	0	56.00
60.00	06000	LABORATORY	81,454	27,217,502	0.002993	436,110	1,305	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,179	2,115,390	0.018048	147,126	2,655	65.00
66.00	06600	PHYSICAL THERAPY	93,856	2,947,113	0.031847	33,398	1,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,651	984,172	0.005742	8,171	47	67.00
68.00	06800	SPEECH PATHOLOGY	3,732	204,098	0.018285	3,707	68	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,134	57,505	0.054500	0	0	70.00
70.01	07001	CARDIOPULMONARY	22,721	306,550	0.074118	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,405	15,924,518	0.001784	223,912	399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,661	1,449,123	0.010807	164,750	1,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,114	12,002,141	0.003509	384,716	1,350	73.00
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	21,473	4,590,825	0.004677	0	0	88.00
90.00	09000	CLINIC	8,693	161,971	0.053670	0	0	90.00
90.01	09001	PAIN MANAGEMENT	62,764	2,416,247	0.025976	785	20	90.01
90.02	09002	CLINIC - LAKESIDE	90,218	4,183,562	0.021565	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	67,849	4,495,166	0.015094	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	55,249	763,803	0.072334	0	0	90.04
90.05	09005	ORTHO CLINIC	13,649	736,735	0.018526	0	0	90.05
91.00	09100	EMERGENCY	150,146	12,664,010	0.011856	19,705	234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	207,584	4,255,199	0.048784	14,182	692	92.00
93.00	04950	BEHAVIOR HEALTH	80,313	1,538,743	0.052194	0	0	93.00
200.00		Total (lines 50 through 199)	1,662,323	144,719,357		1,893,541	15,722	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	0	70.01
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
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0	0	0	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	BEHAVIOR HEALTH	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 11:12 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	13,448,269	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	682,998	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,746,845	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,336,651	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,511,120	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	979,101	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	27,217,502	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,115,390	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,947,113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	984,172	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	204,098	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	57,505	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	306,550	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,924,518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,449,123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,002,141	0.000000	73.00
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	4,590,825	0.000000	88.00
90.00	09000	CLINIC	0	0	0	161,971	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	2,416,247	0.000000	90.01
90.02	09002	CLINIC - LAKESIDE	0	0	0	4,183,562	0.000000	90.02
90.03	09003	CLINIC - QUICKCARE	0	0	0	4,495,166	0.000000	90.03
90.04	09004	WOMENS HEALTH CLINIC	0	0	0	763,803	0.000000	90.04
90.05	09005	ORTHO CLINIC	0	0	0	736,735	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	12,664,010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,255,199	0.000000	92.00
93.00	04950	BEHAVIOR HEALTH	0	0	0	1,538,743	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	144,719,357		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 11:12 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	165,034	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	26,899	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	186,153	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	78,893	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	436,110	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	147,126	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	33,398	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,171	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,707	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	223,912	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	164,750	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	384,716	0	0	0	73.00
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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	785	0	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.000000	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.000000	0	0	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	19,705	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	14,182	0	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		1,893,541	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.346763	0	6,800,173	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.334373	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021778	0	331,929	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100467	0	5,730,869	0	0	54.00
54.01	05401	ULTRASOUND	0.092228	0	878,190	0	0	54.01
56.00	05600	RADIOISOTOPE	0.168632	0	291,456	0	0	56.00
60.00	06000	LABORATORY	0.136826	0	6,248,229	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.530865	0	573,581	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.537411	0	1,101,893	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415502	0	263,890	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.845109	0	17,355	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.242118	0	10,850	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.558669	0	183,035	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112934	0	1,509,204	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.721438	0	312,716	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222217	0	3,025,828	77,031	0	73.00
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
90.00	09000	CLINIC	0.629347	0	115,347	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.608001	0	0	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.244675	0	81,610	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.185054	0	33,407	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.628405	0	14,779	0	0	90.04
90.05	09005	ORTHO CLINIC	0.419464	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.342270	0	2,615,615	6,976	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.023876	0	1,289,830	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.653097	0	429,746	0	0	93.00
200.00		Subtotal (see instructions)		0	31,859,532	84,007	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	31,859,532	84,007	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 11:12 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	2,358,048	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	7,229	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	575,763	0		54.00
54.01	05401	ULTRASOUND	80,994	0		54.01
56.00	05600	RADIOISOTOPE	49,149	0		56.00
60.00	06000	LABORATORY	854,920	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	304,494	0		65.00
66.00	06600	PHYSICAL THERAPY	592,169	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	109,647	0		67.00
68.00	06800	SPEECH PATHOLOGY	14,667	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,627	0		70.00
70.01	07001	CARDIOPULMONARY	102,256	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	170,440	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	225,605	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	672,390	17,118		73.00
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
90.00	09000	CLINIC	72,593	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	CLINIC - LAKESIDE	19,968	0		90.02
90.03	09003	CLINIC - QUICKCARE	6,182	0		90.03
90.04	09004	WOMENS HEALTH CLINIC	9,287	0		90.04
90.05	09005	ORTHO CLINIC	0	0		90.05
91.00	09100	EMERGENCY	895,247	2,388		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,320,626	0		92.00
93.00	04950	BEHAVIOR HEALTH	280,666	0		93.00
200.00		Subtotal (see instructions)	8,724,967	19,506		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,724,967	19,506		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 11:12 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.346763	0	252,117	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.334373	0	9,260	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021778	0	37,565	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100467	0	629,098	0	0	54.00
54.01	05401	ULTRASOUND	0.092228	0	61,261	0	0	54.01
56.00	05600	RADIOISOTOPE	0.168632	0	14,404	0	0	56.00
60.00	06000	LABORATORY	0.136826	0	570,813	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.530865	0	50,655	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.537411	0	31,329	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415502	0	19,349	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.845109	0	15,774	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.242118	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.558669	0	2,508	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112934	0	307,919	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.721438	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222217	0	78,010	0	0	73.00
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
90.00	09000	CLINIC	0.629347	0	8,475	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.608001	0	66,590	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.244675	0	0	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.185054	0	128	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.628405	0	0	0	0	90.04
90.05	09005	ORTHO CLINIC	0.419464	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.342270	0	513,126	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.023876	0	148,335	0	0	92.00
93.00	04950	BEHAVIOR HEALTH	0.653097	0	12,727	0	0	93.00
200.00		Subtotal (see instructions)		0	2,829,443	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	2,829,443	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 11:12 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	87,425	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,096	0		52.00
53.00	05300	ANESTHESIOLOGY	818	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,204	0		54.00
54.01	05401	ULTRASOUND	5,650	0		54.01
56.00	05600	RADIOISOTOPE	2,429	0		56.00
60.00	06000	LABORATORY	78,102	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	26,891	0		65.00
66.00	06600	PHYSICAL THERAPY	16,837	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,040	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,331	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	CARDIOPULMONARY	1,401	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,775	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,335	0		73.00
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
90.00	09000	CLINIC	5,334	0		90.00
90.01	09001	PAIN MANAGEMENT	40,487	0		90.01
90.02	09002	CLINIC - LAKESIDE	0	0		90.02
90.03	09003	CLINIC - QUICKCARE	24	0		90.03
90.04	09004	WOMENS HEALTH CLINIC	0	0		90.04
90.05	09005	ORTHO CLINIC	0	0		90.05
91.00	09100	EMERGENCY	175,628	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	151,877	0		92.00
93.00	04950	BEHAVIOR HEALTH	8,312	0		93.00
200.00		Subtotal (see instructions)	740,996	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	740,996	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 11:12 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)	2,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,745	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)	1,221	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	75	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	25	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)	509	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)	75	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	232.83	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,067,617	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)	5,821	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)	220,230	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,847,387	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,847,387	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,858.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,455,124	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,455,124	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	497,419	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,952,543	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)	214,409	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	214,409	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,524	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,858.79	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 11:12 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,356,796	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	384,393	8,067,617	0.047646	4,356,796	207,584	90.00
91.00	Nursing Program cost	0	8,067,617	0.000000	4,356,796	0	91.00
92.00	Allied health cost	0	8,067,617	0.000000	4,356,796	0	92.00
93.00	All other Medical Education	0	8,067,617	0.000000	4,356,796	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 11:12 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)	2,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,745	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)	1,221	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	75	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	25	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	104	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	223	15.00
16.00	Nursery days (title V or XIX only)	142	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,067,617	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	214,565	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,853,052	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,853,052	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,860.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	297,529	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)	297,529	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 11:12 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)	420,961	223	1,887.72	142	268,056	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	25,668	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)	591,253	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)	1,524	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,860.86	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 11:12 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,359,951	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	384,393	8,067,617	0.047646	4,359,951	207,734	90.00
91.00	Nursing Program cost	0	8,067,617	0.000000	4,359,951	0	91.00
92.00	Allied health cost	0	8,067,617	0.000000	4,359,951	0	92.00
93.00	All other Medical Education	0	8,067,617	0.000000	4,359,951	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 11:12 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		1,288,287		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.346763	165,034	57,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.334373	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021778	26,899	586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100467	186,153	18,702	54.00
54.01	05401	ULTRASOUND	0.092228	78,893	7,276	54.01
56.00	05600	RADIOISOTOPE	0.168632	0	0	56.00
60.00	06000	LABORATORY	0.136826	436,110	59,671	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.530865	147,126	78,104	65.00
66.00	06600	PHYSICAL THERAPY	0.537411	33,398	17,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415502	8,171	3,395	67.00
68.00	06800	SPEECH PATHOLOGY	0.845109	3,707	3,133	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.242118	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.558669	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112934	223,912	25,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.721438	164,750	118,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222217	384,716	85,490	73.00
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
90.00	09000	CLINIC	0.629347	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.608001	785	477	90.01
90.02	09002	CLINIC - LAKESIDE	0.244675	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.185054	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.628405	0	0	90.04
90.05	09005	ORTHO CLINIC	0.419464	0	0	90.05
91.00	09100	EMERGENCY	0.342270	19,705	6,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.023876	14,182	14,521	92.00
93.00	04950	BEHAVIOR HEALTH	0.653097	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,893,541	497,419	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)		1,893,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.346763	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.334373	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021778	334	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100467	1,382	139	54.00
54.01	05401	ULTRASOUND	0.092228	0	0	54.01
56.00	05600	RADIOISOTOPE	0.168632	0	0	56.00
60.00	06000	LABORATORY	0.136826	22,801	3,120	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.530865	13,399	7,113	65.00
66.00	06600	PHYSICAL THERAPY	0.537411	15,415	8,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415502	9,504	3,949	67.00
68.00	06800	SPEECH PATHOLOGY	0.845109	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.242118	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.558669	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112934	18,225	2,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.721438	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222217	18,140	4,031	73.00
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
90.00	09000	CLINIC	0.629347	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.608001	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.244675	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.185054	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.628405	0	0	90.04
90.05	09005	ORTHO CLINIC	0.419464	0	0	90.05
91.00	09100	EMERGENCY	0.342270	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.023876	4,158	4,257	92.00
93.00	04950	BEHAVIOR HEALTH	0.653097	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		103,358	32,958	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)		103,358		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 11:12 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		18,308		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		24,978		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.346763	1,764	612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.334373	5,472	1,830	52.00
53.00	05300	ANESTHESIOLOGY	0.021778	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100467	6,985	702	54.00
54.01	05401	ULTRASOUND	0.092228	1,899	175	54.01
56.00	05600	RADIOISOTOPE	0.168632	0	0	56.00
60.00	06000	LABORATORY	0.136826	40,140	5,492	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.530865	5,393	2,863	65.00
66.00	06600	PHYSICAL THERAPY	0.537411	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415502	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.845109	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.242118	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.558669	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112934	47,901	5,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.721438	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222217	5,848	1,300	73.00
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	0.831538	0	0	88.00
90.00	09000	CLINIC	0.629347	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.608001	0	0	90.01
90.02	09002	CLINIC - LAKESIDE	0.244675	0	0	90.02
90.03	09003	CLINIC - QUICKCARE	0.185054	0	0	90.03
90.04	09004	WOMENS HEALTH CLINIC	0.628405	0	0	90.04
90.05	09005	ORTHO CLINIC	0.419464	0	0	90.05
91.00	09100	EMERGENCY	0.342270	13,968	4,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.023876	2,445	2,503	92.00
93.00	04950	BEHAVIOR HEALTH	0.653097	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		131,815	25,668	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)		131,815		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,744,473	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)	8,744,473	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)	8,831,918	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)	101,959	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,106,781	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,623,178	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)	3,623,178	30.00
31.00	Primary payer payments	5,198	31.00
32.00	Subtotal (line 30 minus line 31)	3,617,980	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)	1,087,751	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	707,038	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	753,357	36.00
37.00	Subtotal (see instructions)	4,325,018	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)	4,325,018	40.00
40.01	Sequestration adjustment (see instructions)	86,500	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	4,279,334	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)	-40,816	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/23/2024 11:12 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: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,265,261		4,085,534	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	08/09/2023	192,500	08/08/2023	193,800	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)		192,500		193,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,457,761		4,279,334	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		335,898		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		40,816	6.02
7.00	Total Medicare program liability (see instructions)		1,793,659		4,238,518	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: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2024 11:12 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		171,084		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	08/09/2023	39,800		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)		39,800		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)		210,884		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		32,196		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		243,080		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 - SWING BEDS

Provider CCN: 15-1327 | Component CCN: 15-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/23/2024 11:12 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)	216,553	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)	33,288	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	75	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)	249,841	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	249,841	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)	249,841	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	248,041	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)	248,041	0	19.00
19.01	Sequestration adjustment (see instructions)	4,961	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	210,884	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)	32,196	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: 15-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/23/2024 11:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,952,543	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,952,543	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,952,543	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,952,543	19.00
20.00	Deductibles (exclude professional component)	166,180	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,786,363	22.00
23.00	Coinsurance	11,200	23.00
24.00	Subtotal (line 22 minus line 23)	1,775,163	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	84,771	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	55,101	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,452	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,830,264	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,830,264	30.00
30.01	Sequestration adjustment (see instructions)	36,605	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,457,761	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)	335,898	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 5/23/2024 11:12 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	591,253		1.00
2.00	Medical and other services		740,996	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	591,253	740,996	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)	591,253	740,996	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	131,815	2,829,443	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)	131,815	2,829,443	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)	131,815	2,829,443	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	2,088,447	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	459,438	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)	591,253	740,996	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)	591,253	740,996	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	459,438	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	591,253	740,996	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)	591,253	740,996	36.00
37.00	OTHER ADJUSTMENTS	-591,253	-740,996	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/23/2024 11:12 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,209,300	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	15,238,038	0	0	0	4.00
5.00	Other receivable	1,170,228	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,991,843	0	0	0	6.00
7.00	Inventory	757,056	0	0	0	7.00
8.00	Prepaid expenses	1,516,039	0	0	0	8.00
9.00	Other current assets	382,121	0	0	0	9.00
10.00	Due from other funds	1,548,867	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,829,806	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,036,127	0	0	0	12.00
13.00	Land improvements	3,689,780	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	20,087,954	0	0	0	15.00
16.00	Accumulated depreciation	-34,584,430	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	6,641,566	0	0	0	19.00
20.00	Accumulated depreciation	-1,050,581	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	25,409,569	0	0	0	23.00
24.00	Accumulated depreciation	-3,160,504	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)	18,069,481	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	24,727,453	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,727,453	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,626,740	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,585,686	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,784,170	0	0	0	38.00
39.00	Payroll taxes payable	-63,637	0	0	0	39.00
40.00	Notes and loans payable (short term)	360,155	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,426,625	0	0	0	43.00
44.00	Other current liabilities	4,673,207	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,766,206	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,942,427	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,942,427	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,708,633	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	45,918,107				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)	45,918,107	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,626,740	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/23/2024 11:12 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		43,400,287		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,423,108				2.00
3.00	Total (sum of line 1 and line 2)		45,823,395		0		3.00
4.00	VARIANCE	94,712		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)		94,712		0		10.00
11.00	Subtotal (line 3 plus line 10)		45,918,107		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,918,107		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	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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/23/2024 11:12 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,525,286		6,525,286	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)	6,525,286		6,525,286	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,525,286		6,525,286	17.00
18.00	Ancillary services	7,916,725	107,602,988	115,519,713	18.00
19.00	Outpatient services	4,992,988	24,012,938	29,005,926	19.00
20.00	RURAL HEALTH CLINIC	0	4,590,825	4,590,825	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUE	242,178	841,722	1,083,900	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,677,177	137,048,473	156,725,650	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,711,926		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)		56,711,926		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/23/2024 11:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	156,725,650	1.00
2.00	Less contractual allowances and discounts on patients' accounts	104,559,874	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,165,776	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,711,926	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,546,150	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,947,770	7.00
8.00	Revenues from telephone and other miscellaneous communication services	736	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	4,473	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	224,670	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	3,638,095	17.00
18.00	Revenue from sale of medical records and abstracts	4,111	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	181,453	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	967,950	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	6,969,258	25.00
26.00	Total (line 5 plus line 25)	2,423,108	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)	2,423,108	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 11:12 am

RHC I

		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	874,063	0	874,063	-3,843	870,220	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	458,852	0	458,852	-2,017	456,835	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	526,821	0	526,821	-2,316	524,505	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,859,736	0	1,859,736	-8,176	1,851,560	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	173,401	173,401	-762	172,639	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	173,401	173,401	-762	172,639	14.00
15.00	Medical Supplies	0	98,898	98,898	0	98,898	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	98,898	98,898	0	98,898	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,859,736	272,299	2,132,035	-8,938	2,123,097	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	10,093	10,093	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	337	337	-1	336	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	337	337	10,092	10,429	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	237,379	237,379	-1,044	236,335	29.00
30.00	Administrative Costs	0	25,068	25,068	-110	24,958	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	262,447	262,447	-1,154	261,293	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,859,736	535,083	2,394,819	0	2,394,819	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 11:12 am

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	870,220		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	456,835		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
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	524,505		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,851,560		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	172,639		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	172,639		14.00
15.00	Medical Supplies	-88,434	10,464		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)	-88,434	10,464		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-88,434	2,034,663		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	10,093		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	-337	-1		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-337	10,092		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-4,864	231,471		29.00
30.00	Administrative Costs	0	24,958		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,864	256,429		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-93,635	2,301,184		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 11:12 am

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.89	8,572	4,200	7,938		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.57	9,319	2,100	3,297		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.46	17,891		11,235	17,891	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.46	17,891			17,891	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,034,663	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	10,092	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,044,755	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.995064	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	256,429	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,516,263	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,772,692	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,772,692	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,763,942	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,798,605	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1327 Component CCN: 15-8540	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 11:12 am
	Title XVIII	RHC I	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,798,605	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		56,413	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,742,192	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,891	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,891	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		209.17	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	182.37	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	182.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,793	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	509,359	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	509,359	16.00
16.01	Total program charges (see instructions)(from contractor's records)		605,014	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		375,968	16.04
16.05	Total program cost (see instructions)	0	375,968	16.05
17.00	Primary payer amounts		233	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,399	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		112,913	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		375,735	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,014	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)		389,749	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)		389,749	26.00
26.01	Sequestration adjustment (see instructions)		7,795	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		367,510	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)		14,444	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/23/2024 11:12 am

Title XVIII | RHC I

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,851,560	1,851,560	1,851,560	1,851,560	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000429	0.004983	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	794	9,226	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,609	13,588	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,403	22,814	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,034,663	2,034,663	2,034,663	2,034,663	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,763,942	1,763,942	1,763,942	1,763,942	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003638	0.011213	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,417	19,779	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13,820	42,593	0	0	10.00
11.00	Total number of injections/infusions (from your records)	37	430	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	373.51	99.05	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	100	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,109	9,905	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		56,413	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		14,014	16.00

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

Provider CCN: 15-1327 | Component CCN: 15-8540 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/23/2024 11:12 am

RHC I

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		367,510	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)		367,510	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		14,444	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		381,954	7.00

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