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: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 7:26 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 7:26 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 WOODLAWN HOSPITAL (15-1313) 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	Alan Fisher		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Alan Fisher			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	189,603	-501,563	0	-15,178	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	56,131	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		2,549		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-53,815		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-37,198		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-27,151		0	10.03
10.04	RURAL HEALTH CLINIC V	0		-39,144		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		-40,635		0	10.05
200.00	TOTAL	0	245,734	-696,957	0	-15,178	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 7:26 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1400 EAST 9TH STREET	PO Box:			1.00
2.00	City: ROCHESTER	State: IN	Zip Code: 46975-	County: FULTON	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	WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WOODLAWN HOSPITAL SWINGBED	15Z313	99915		10/23/2001	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	SHAFER MEDICAL CENTER	158551	99915		04/13/2020	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	WOODLAWN MEDICAL PROFESSIONALS	158552	99915		04/13/2020	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	FULTON COUNTY MEDICAL CENTER - MAIN	158550	99915		04/13/2020	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	FULTON COUNTY MEDICAL CENTER - DUNN	158549	99915		04/13/2020	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	AKRON MEDICAL CLINIC	158547	99915		04/13/2020	N	O	O	15.04
15.05	Hospital-Based Health Clinic - RHC VI	ARGOS MEDICAL CLINIC	158548	99915		04/13/2020	N	O	O	15.05
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)	8		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 7:26 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:26 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:26 am

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

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

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

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

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

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

	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00
		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
				1.00	
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 7:26 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	276,624	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		N		123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 7:26 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	05/07/2024	Y	05/07/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO. LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 7:26 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	35,424.00	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	35,424.00	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	35,424.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 7:26 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)	487	47	1,476			1.00
2.00	HMO and other (see instructions)	310	402				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	97	0	97			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	214			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	584	47	1,787			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	334			13.00
14.00	Total (see instructions)	584	47	2,121	0.00	238.52	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,292	789	5,469	0.00	6.23	26.00
26.01	RURAL HEALTH CLINIC II	456	7,635	19,399	0.00	20.39	26.01
26.02	RURAL HEALTH CLINIC III	2,296	3,546	14,573	0.00	15.25	26.02
26.03	RURAL HEALTH CLINIC IV	399	581	2,081	0.00	0.62	26.03
26.04	RURAL HEALTH CLINIC V	850	1,007	5,763	0.00	6.68	26.04
26.05	RURAL HEALTH CLINIC VI	2,363	4,427	19,167	0.00	14.26	26.05
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	301.95	27.00
28.00	Observation Bed Days		0	976			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	83	130			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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 7:26 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	142	16	504	1.00
2.00	HMO and other (see instructions)			75	167		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	142	16	504	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1430 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	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?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1400 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	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: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			700 MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	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: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			100 EAST DUNN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FULTON		IN	46931	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: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC IV | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC V | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			105 SR 14 N		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	AKRON		IN	46910	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?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
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: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC V | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC VI | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			530 N MICHIGAN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ARGOS		IN	46501	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: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 7:26 am

RHC VI | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 7:26 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)	0.298918	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	129,519	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	29,589,653	6.00
7.00	Medicaid cost (line 1 times line 6)	8,844,880	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	8,715,361	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,715,361	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)	278,778	0	278,778	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	83,332	0	83,332	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	83,332	0	83,332	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)	2,016,007	26.00
27.00	Medicare reimbursable bad debts (see instructions)	246,983	27.00
27.01	Medicare allowable bad debts (see instructions)	379,973	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,636,034	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	622,030	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	705,362	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,420,723	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 7:26 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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 7:26 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		2,544,144	2,544,144	-133,980	2,410,164	1.00
1.02	00102	AKRON BUILDING		19,986	19,986	0	19,986	1.02
1.03	00103	ARGOS BUILDING		80,898	80,898	0	80,898	1.03
1.04	00101	CLAYS BUILDING		49,856	49,856	133,980	183,836	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,189,371	1,189,371	0	1,189,371	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,066,096	8,196,782	12,262,878	226,946	12,489,824	5.00
7.00	00700	OPERATION OF PLANT	496,663	1,215,286	1,711,949	1,339,218	3,051,167	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,354	137,644	167,998	0	167,998	8.00
9.00	00900	HOUSEKEEPING	391,400	181,109	572,509	-536	571,973	9.00
10.00	01000	DIETARY	480,495	355,816	836,311	-561,327	274,984	10.00
11.00	01100	CAFETERIA	0	0	0	556,788	556,788	11.00
13.00	01300	NURSING ADMINISTRATION	202,233	83,251	285,484	354,804	640,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	375,468	3,346,656	3,722,124	-33,027	3,689,097	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	401,268	1,017,586	1,418,854	-45,237	1,373,617	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,643,378	949,669	3,593,047	-1,065,696	2,527,351	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	516,846	516,846	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	723,183	1,910,352	2,633,535	-235,866	2,397,669	50.00
51.00	05100	RECOVERY ROOM	481,300	177,390	658,690	0	658,690	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	162,745	162,745	52.00
53.00	05300	ANESTHESIOLOGY	0	1,017,843	1,017,843	-795	1,017,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,002	1,484,231	3,170,233	-228,611	2,941,622	54.00
60.00	06000	LABORATORY	967,326	2,062,643	3,029,969	-96,851	2,933,118	60.00
65.00	06500	RESPIRATORY THERAPY	1,127,610	398,118	1,525,728	-11,106	1,514,622	65.00
66.00	06600	PHYSICAL THERAPY	616,554	155,262	771,816	-205	771,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,934	30,307	200,241	0	200,241	67.00
68.00	06800	SPEECH PATHOLOGY	82,233	20,042	102,275	0	102,275	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	804,113	804,113	0	804,113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	348,944	760,657	1,109,601	88,030	1,197,631	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,646,822	1,513,643	4,160,465	-713,589	3,446,876	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,569,337	938,342	2,507,679	-31,146	2,476,533	88.02
88.03	08803	RURAL HEALTH CLINIC IV	188,403	46,320	234,723	19,018	253,741	88.03
88.04	08804	RURAL HEALTH CLINIC V	705,687	231,051	936,738	-15,033	921,705	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,283,902	1,244,649	2,528,551	-15,477	2,513,074	88.05
91.00	09100	EMERGENCY	1,359,215	3,459,283	4,818,498	-6,750	4,811,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,245,693	113,829	1,359,522	-3,430	1,356,092	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,495,836	484,356	1,980,192	-81,129	1,899,063	93.01
93.02	04040	INTERNAL MEDICINE	787,980	55,938	843,918	-1,545	842,373	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,573,316	36,276,423	62,849,739	117,039	62,966,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	83,859	167,569	251,428	-117,039	134,389	194.00
194.01	07951	LTC/WELLNESS	167,522	49,521	217,043	0	217,043	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	26,824,697	36,493,513	63,318,210	0	63,318,210	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 7:26 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	-15,313	2,394,851		1.00
1.02	00102	AKRON BUILDING	0	19,986		1.02
1.03	00103	ARGOS BUILDING	0	80,898		1.03
1.04	00101	CLAYS BUILDING	0	183,836		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,189,371		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,313,178	8,176,646		5.00
7.00	00700	OPERATION OF PLANT	0	3,051,167		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	167,998		8.00
9.00	00900	HOUSEKEEPING	0	571,973		9.00
10.00	01000	DIETARY	-24,806	250,178		10.00
11.00	01100	CAFETERIA	-115,446	441,342		11.00
13.00	01300	NURSING ADMINISTRATION	0	640,288		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-3,939	3,685,158		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-112	1,373,505		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,527,351		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	516,846		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,397,669		50.00
51.00	05100	RECOVERY ROOM	0	658,690		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	162,745		52.00
53.00	05300	ANESTHESIOLOGY	-953,767	63,281		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-228,090	2,713,532		54.00
60.00	06000	LABORATORY	0	2,933,118		60.00
65.00	06500	RESPIRATORY THERAPY	-180,733	1,333,889		65.00
66.00	06600	PHYSICAL THERAPY	-4,239	767,372		66.00
67.00	06700	OCCUPATIONAL THERAPY	-14,891	185,350		67.00
68.00	06800	SPEECH PATHOLOGY	0	102,275		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	804,113		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-26,377	1,171,254		88.00
88.01	08801	RURAL HEALTH CLINIC II	-139,799	3,307,077		88.01
88.02	08802	RURAL HEALTH CLINIC III	-77,587	2,398,946		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	253,741		88.03
88.04	08804	RURAL HEALTH CLINIC V	-16,357	905,348		88.04
88.05	08805	RURAL HEALTH CLINIC VI	-30,921	2,482,153		88.05
91.00	09100	EMERGENCY	-1,231,981	3,579,767		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	-1,134,022	222,070		93.00
93.01	04951	SHAFER MEDICAL CENTER	-1,403,389	495,674		93.01
93.02	04040	INTERNAL MEDICINE	-710,038	132,335		93.02
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,624,985	52,341,793		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	FCMC	0	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	134,389		194.00
194.01	07951	LTC/WELLNESS	0	217,043		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,624,985	52,693,225		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 7:26 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	321,643	235,145		1.00
	0		321,643	235,145		
	B - ADVERTISING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	39,036	78,003		1.00
	0		39,036	78,003		
	C - DEPRECIATION RECLASS					
1.00	CLAYS BUILDING	1.04	0	133,980		1.00
	0		0	133,980		
	D - NURSERY RECLASS					
1.00	NURSERY	43.00	413,826	103,020		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	130,306	32,439		2.00
	0		544,132	135,459		
	E - NURSING SUPERVISOR RECLASS					
1.00	NURSING ADMINISTRATION	13.00	358,029	0		1.00
2.00		0.00	0	0		2.00
	0		358,029	0		
	F - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,339,218		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	0		0	1,339,218		
	G - RENT RECLASS					
1.00	RURAL HEALTH CLINIC IV	88.03	0	12,730		1.00
	0		0	12,730		
	H - RHC OVERHEAD RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	663,784		1.00
2.00	RURAL HEALTH CLINIC	88.00	5,789	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	15,425	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	2,203	0		4.00
5.00	RURAL HEALTH CLINIC V	88.04	6,100	0		5.00
6.00	RURAL HEALTH CLINIC VI	88.05	20,288	0		6.00
	0		49,805	663,784		
	J - CLINIC SUPERVISOR					
1.00	RURAL HEALTH CLINIC	88.00	12,905	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	35,548	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	4,085	0		3.00
	0		52,538	0		
	K - NP RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	69,389	0		1.00
	TOTALS		69,389	0		
500.00	Grand Total: Increases		1,434,572	2,598,319		500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 7:26 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	321,643	235,145	0		1.00
	0		321,643	235,145			
	B - ADVERTISING RECLASS						
1.00	ADVERTISING	194.00	39,036	78,003	0		1.00
	0		39,036	78,003			
	C - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,980	9		1.00
	0		0	133,980			
	D - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	544,132	135,459	0		1.00
2.00		0.00	0	0	0		2.00
	0		544,132	135,459			
	E - NURSING SUPERVISOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	354,938	0	0		1.00
2.00	OPERATING ROOM	50.00	3,091	0	0		2.00
	0		358,029	0			
	F - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	553,877	0		1.00
2.00	HOUSEKEEPING	9.00	0	536	0		2.00
3.00	DIETARY	10.00	0	4,539	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,225	0		4.00
5.00	PHARMACY	15.00	0	33,027	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	45,237	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	31,167	0		7.00
8.00	OPERATING ROOM	50.00	0	232,775	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	795	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	228,611	0		10.00
11.00	LABORATORY	60.00	0	96,851	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	11,106	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	205	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	53	0		14.00
15.00	RURAL HEALTH CLINIC V	88.04	0	21,133	0		15.00
16.00	RURAL HEALTH CLINIC VI	88.05	0	35,765	0		16.00
17.00	EMERGENCY	91.00	0	6,750	0		17.00
18.00	WOODLAWN MEDICAL PROFESSIONALS	93.00	0	3,430	0		18.00
19.00	SHAFER MEDICAL CENTER	93.01	0	28,591	0		19.00
20.00	INTERNAL MEDICINE	93.02	0	1,545	0		20.00
	0		0	1,339,218			
	G - RENT RECLASS						
1.00	RURAL HEALTH CLINIC III	88.02	0	12,730	0		1.00
	0		0	12,730			
	H - RHC OVERHEAD RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	49,805	663,784	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		49,805	663,784			
	J - CLINIC SUPERVISOR						
1.00	SHAFER MEDICAL CENTER	93.01	52,538	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		52,538	0			
	K - NP RECLASS						
1.00	RURAL HEALTH CLINIC III	88.02	69,389	0	0		1.00
	TOTALS		69,389	0			
500.00	Grand Total: Decreases		1,434,572	2,598,319			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 7:26 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	513,782	316,879	0	316,879	0	2.00
3.00	Buildings and Fixtures	29,635,140	1,621,693	0	1,621,693	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	16,309,970	840,042	0	840,042	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,055,108	2,778,614	0	2,778,614	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,055,108	2,778,614	0	2,778,614	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	596,216	0	1.00
2.00	Land Improvements	830,661	0	2.00
3.00	Buildings and Fixtures	31,256,833	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	17,150,012	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,833,722	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	49,833,722	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 7:26 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	1,512,774	0	372,004	619,941	0	1.00
1.02	AKRON BUILDING	441	0	0	0	0	1.02
1.03	ARGOS BUILDING	1,353	0	0	45,131	0	1.03
1.04	CLAYS BUILDING	0	0	0	0	0	1.04
3.00	Total (sum of lines 1-2)	1,514,568	0	372,004	665,072	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	39,425	2,544,144	1.00
1.02	AKRON BUILDING	19,545	19,986	1.02
1.03	ARGOS BUILDING	34,414	80,898	1.03
1.04	CLAYS BUILDING	49,856	49,856	1.04
3.00	Total (sum of lines 1-2)	143,240	2,694,884	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2024 7:26 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	38,672,671	0	38,672,671	0.776034	0	1.00
1.02	AKRON BUILDING	1,243,551	0	1,243,551	0.024954	0	1.02
1.03	ARGOS BUILDING	2,664,753	0	2,664,753	0.053473	0	1.03
1.04	CLAYS BUILDING	7,252,747	0	7,252,747	0.145539	0	1.04
3.00	Total (sum of lines 1-2)	49,833,722	0	49,833,722	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	1,378,153	0	1.00
1.02	AKRON BUILDING	0	0	0	441	0	1.02
1.03	ARGOS BUILDING	0	0	0	1,353	0	1.03
1.04	CLAYS BUILDING	0	0	0	133,980	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,513,927	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	357,332	619,941	0	39,425	2,394,851	1.00
1.02	AKRON BUILDING	0	0	0	19,545	19,986	1.02
1.03	ARGOS BUILDING	0	45,131	0	34,414	80,898	1.03
1.04	CLAYS BUILDING	0	0	0	49,856	183,836	1.04
3.00	Total (sum of lines 1-2)	357,332	665,072	0	143,240	2,679,571	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 7:26 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	-14,672	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.02	Investment income - AKRON BUILDING (chapter 2)		0	AKRON BUILDING	1.02	0	1.02
1.03	Investment income - ARGOS BUILDING (chapter 2)		0	ARGOS BUILDING	1.03	0	1.03
1.04	Investment income - CLAYS BUILDING (chapter 2)		0	CLAYS BUILDING	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,664,487			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-115,446	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-112	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	CAFETERIA	11.00	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
26.02	Depreciation - AKRON BUILDING		0	AKRON BUILDING	1.02	0	26.02
26.03	Depreciation - ARGOS BUILDING		0	ARGOS BUILDING	1.03	0	26.03
26.04	Depreciation - CLAYS BUILDING		0	CLAYS BUILDING	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 7:26 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	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	B	-641	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	-4,688	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT	A	-64,350	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	HAF EXPENSE	A	-4,155,584	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADMIN OTHER REVENUE	B	-2,648	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	HOME MEAL PROGRAM	B	-24,806	DIETARY	10.00	0	36.00
37.00	DRUG SALES	B	-3,939	PHARMACY	15.00	0	37.00
38.00	PT - OTHER REVENUE	B	-4,239	PHYSICAL THERAPY	66.00	0	38.00
39.00	OCC THER OTH REV	B	-14,891	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	MISC REV -OTH REV	B	-47,617	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	STAFF RENTAL AGREEMENTS	B	-177,533	RESPIRATORY THERAPY	65.00	0	41.00
42.00	IHA & AHA LOBBYING	A	-2,272	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	PART B BILLING OFFSET	A	-19,173	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LTC EXPENSES	A	-16,846	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	RHC OFFSETS	A	-26,377	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	RHC OFFSETS	A	-139,799	RURAL HEALTH CLINIC II	88.01	0	45.01
45.02	RHC OFFSETS	A	-77,587	RURAL HEALTH CLINIC III	88.02	0	45.02
45.03	RHC OFFSETS	A	-16,357	RURAL HEALTH CLINIC V	88.04	0	45.03
45.04	RHC OFFSETS	A	-30,921	RURAL HEALTH CLINIC VI	88.05	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,624,985				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 7:26 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	53.00	ANESTHESIOLOGY	965,767	953,767	12,000	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	228,090	228,090	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	33,658	3,200	30,458	0	0	3.00
4.00	91.00	EMERGENCY	2,548,671	1,231,981	1,316,690	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	1,134,022	1,134,022	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	1,403,389	1,403,389	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	710,038	710,038	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,023,635	5,664,487	1,359,148		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	953,767		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	228,090		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	3,200		3.00
4.00	91.00	EMERGENCY	0	0	0	1,231,981		4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,134,022		5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	1,403,389		6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	710,038		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,664,487		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,394,851	2,394,851				1.00
1.02	00102	AKRON BUILDING	19,986	0	19,986			1.02
1.03	00103	ARGOS BUILDING	80,898	0	0	80,898		1.03
1.04	00101	CLAYS BUILDING	183,836	0	0	0	183,836	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,189,371	2,828	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,176,646	253,658	2,284	6,472	128	5.00
7.00	00700	OPERATION OF PLANT	3,051,167	235,658	1,370	7,378	37,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	167,998	7,204	0	0	0	8.00
9.00	00900	HOUSEKEEPING	571,973	26,282	0	0	345	9.00
10.00	01000	DIETARY	250,178	86,902	0	0	0	10.00
11.00	01100	CAFETERIA	441,342	32,813	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	640,288	57,299	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,685,158	31,107	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,373,505	8,439	0	0	34,083	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,527,351	383,540	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	516,846	4,197	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,397,669	182,153	0	0	0	50.00
51.00	05100	RECOVERY ROOM	658,690	110,804	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,745	19,279	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	63,281	3,075	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,713,532	255,768	0	0	0	54.00
60.00	06000	LABORATORY	2,933,118	58,870	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,333,889	91,166	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	767,372	70,720	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,350	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	102,275	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	804,113	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,171,254	0	0	0	45,193	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,307,077	172,300	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,398,946	0	0	0	20,086	88.02
88.03	08803	RURAL HEALTH CLINIC IV	253,741	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	905,348	0	16,332	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	2,482,153	0	0	67,048	0	88.05
91.00	09100	EMERGENCY	3,579,767	140,452	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	222,070	128,445	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	495,674	0	0	0	46,645	93.01
93.02	04040	INTERNAL MEDICINE	132,335	12,164	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,341,793	2,375,123	19,986	80,898	183,836	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	15,307	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	134,389	4,421	0	0	0	194.00
194.01	07951	LTC/WELLNESS	217,043	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,693,225	2,394,851	19,986	80,898	183,836	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,192,199					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	182,451	8,621,639	8,621,639			5.00
7.00	00700	OPERATION OF PLANT	22,074	3,355,003	656,333	4,011,336		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,349	176,551	34,538	11,578	222,667	8.00
9.00	00900	HOUSEKEEPING	17,395	615,995	120,506	43,785	82,046	9.00
10.00	01000	DIETARY	7,060	344,140	67,323	139,651	5,728	10.00
11.00	01100	CAFETERIA	14,295	488,450	95,554	52,730	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,900	722,487	141,339	92,079	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	16,687	3,732,952	730,270	49,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,834	1,433,861	280,503	166,810	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,524	2,988,415	584,618	616,349	32,522	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	18,392	539,435	105,529	6,745	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,004	2,611,826	510,946	292,720	4,620	50.00
51.00	05100	RECOVERY ROOM	21,391	790,885	154,719	178,063	15,337	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,791	187,815	36,742	30,982	0	52.00
53.00	05300	ANESTHESIOLOGY	0	66,356	12,981	4,941	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,933	3,044,233	595,537	411,020	35,479	54.00
60.00	06000	LABORATORY	42,992	3,034,980	593,727	94,604	0	60.00
65.00	06500	RESPIRATORY THERAPY	50,115	1,475,170	288,585	146,504	3,511	65.00
66.00	06600	PHYSICAL THERAPY	27,402	865,494	169,315	113,647	1,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,553	192,903	37,737	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,655	105,930	20,723	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	804,113	157,307	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	19,423	1,235,870	241,771	203,201	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	115,422	3,594,799	703,243	276,886	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	68,929	2,487,961	486,715	90,312	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	8,653	262,394	51,332	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	31,635	953,315	186,495	103,152	3,326	88.04
88.05	08805	RURAL HEALTH CLINIC VI	57,963	2,607,164	510,034	224,192	2,587	88.05
91.00	09100	EMERGENCY	60,409	3,780,628	739,600	225,707	35,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	55,364	405,879	79,401	206,411	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	64,146	606,465	118,642	209,730	0	93.01
93.02	04040	INTERNAL MEDICINE	35,021	179,520	35,119	19,548	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,182,762	52,312,628	8,547,184	4,011,336	222,667	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	15,307	2,994	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	1,992	140,802	27,545	0	0	194.00
194.01	07951	LTC/WELLNESS	7,445	224,488	43,916	0	0	194.01
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)	1,192,199	52,693,225	8,621,639	4,011,336	222,667	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:26 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
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	862,332					9.00
10.00	01000	DIETARY	738	557,580				10.00
11.00	01100	CAFETERIA	16,357	0	653,091			11.00
13.00	01300	NURSING ADMINISTRATION	640	0	20,314	976,859		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	6,174	0	16,173	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,821	0	28,830	91,326	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	208,318	557,580	80,084	646,912	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	18,673	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,044	0	36,604	0	0	50.00
51.00	05100	RECOVERY ROOM	66,312	0	22,072	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,860	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,054	0	86,099	0	0	54.00
60.00	06000	LABORATORY	38,838	0	63,637	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	33,771	0	58,246	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,448	0	30,158	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,368	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,516	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35,222	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,777	0	79,615	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	22,432	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	98,503	0	58,910	238,621	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	15,791	0	17,189	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	38,542	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	10,157	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	860,782	557,580	642,505	976,859	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,550	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	1,914	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	8,672	0	0	194.01
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)	862,332	557,580	653,091	976,859	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,535,558					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,006,151				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	90,314	5,805,112	0	5,805,112	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,212	673,594	0	673,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	221,469	3,788,229	0	3,788,229	50.00
51.00	05100	RECOVERY ROOM	0	24,503	1,251,891	0	1,251,891	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,948	265,347	0	265,347	52.00
53.00	05300	ANESTHESIOLOGY	0	29,205	113,483	0	113,483	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	489,544	4,746,966	0	4,746,966	54.00
60.00	06000	LABORATORY	0	397,496	4,223,282	0	4,223,282	60.00
65.00	06500	RESPIRATORY THERAPY	0	102,779	2,108,566	0	2,108,566	65.00
66.00	06600	PHYSICAL THERAPY	0	31,733	1,233,458	0	1,233,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,418	249,426	0	249,426	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,348	133,517	0	133,517	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,501	982,921	0	982,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,535,558	233,509	4,769,067	0	4,769,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,569	1,728,633	0	1,728,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	58,917	4,771,237	0	4,771,237	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	34,554	3,099,542	0	3,099,542	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,971	340,129	0	340,129	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	12,832	1,259,120	0	1,259,120	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	44,244	3,388,221	0	3,388,221	88.05
91.00	09100	EMERGENCY	0	108,916	5,286,733	0	5,286,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	16,039	740,710	0	740,710	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	32,807	1,006,186	0	1,006,186	93.01
93.02	04040	INTERNAL MEDICINE	0	16,323	260,667	0	260,667	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,535,558	2,006,151	52,226,037	0	52,226,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1,550	0	1,550	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	18,301	0	18,301	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	170,261	0	170,261	194.00
194.01	07951	LTC/WELLNESS	0	0	277,076	0	277,076	194.01
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)	4,535,558	2,006,151	52,693,225	0	52,693,225	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,828	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	253,658	2,284	6,472	128	5.00
7.00	00700	OPERATION OF PLANT	0	235,658	1,370	7,378	37,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,204	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	26,282	0	0	345	9.00
10.00	01000	DIETARY	0	86,902	0	0	0	10.00
11.00	01100	CAFETERIA	0	32,813	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,299	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	31,107	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,439	0	0	34,083	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	383,540	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	4,197	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	182,153	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	110,804	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,279	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,075	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	255,768	0	0	0	54.00
60.00	06000	LABORATORY	0	58,870	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	91,166	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	70,720	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
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	45,193	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	172,300	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	20,086	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	16,332	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	67,048	0	88.05
91.00	09100	EMERGENCY	0	140,452	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	128,445	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	46,645	93.01
93.02	04040	INTERNAL MEDICINE	0	12,164	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,375,123	19,986	80,898	183,836	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	15,307	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	4,421	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,394,851	19,986	80,898	183,836	202.00

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		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,828	2,828				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	262,542	439	262,981			5.00
7.00	00700	OPERATION OF PLANT	281,762	52	20,019	301,833		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,204	3	1,053	871	9,131	8.00
9.00	00900	HOUSEKEEPING	26,627	41	3,676	3,295	3,365	9.00
10.00	01000	DIETARY	86,902	17	2,053	10,508	235	10.00
11.00	01100	CAFETERIA	32,813	34	2,915	3,968	0	11.00
13.00	01300	NURSING ADMINISTRATION	57,299	59	4,311	6,928	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	31,107	39	22,275	3,761	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,522	42	8,556	12,552	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	383,540	183	17,832	46,379	1,334	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	4,197	43	3,219	507	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182,153	76	15,585	22,026	189	50.00
51.00	05100	RECOVERY ROOM	110,804	51	4,719	13,398	629	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,279	14	1,121	2,331	0	52.00
53.00	05300	ANESTHESIOLOGY	3,075	0	396	372	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,768	177	18,165	30,927	1,455	54.00
60.00	06000	LABORATORY	58,870	102	18,110	7,118	0	60.00
65.00	06500	RESPIRATORY THERAPY	91,166	118	8,802	11,024	144	65.00
66.00	06600	PHYSICAL THERAPY	70,720	65	5,164	8,551	68	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18	1,151	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9	632	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,798	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,193	46	7,374	15,290	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,300	273	21,450	20,834	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,086	163	14,846	6,796	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	20	1,566	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	16,332	75	5,688	7,762	136	88.04
88.05	08805	RURAL HEALTH CLINIC VI	67,048	137	15,557	16,869	106	88.05
91.00	09100	EMERGENCY	140,452	143	22,565	16,983	1,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	128,445	131	2,422	15,531	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	46,645	152	3,619	15,781	0	93.01
93.02	04040	INTERNAL MEDICINE	12,164	83	1,071	1,471	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,659,843	2,805	260,710	301,833	9,131	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	15,307	0	91	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	4,421	5	840	0	0	194.00
194.01	07951	LTC/WELLNESS	0	18	1,340	0	0	194.01
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)	2,679,571	2,828	262,981	301,833	9,131	202.00

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		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
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	37,004					9.00
10.00	01000	DIETARY	32	99,747				10.00
11.00	01100	CAFETERIA	702	0	40,432			11.00
13.00	01300	NURSING ADMINISTRATION	27	0	1,258	69,882		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	265	0	1,001	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207	0	1,785	6,533	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,939	99,747	4,958	46,279	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,156	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,722	0	2,266	0	0	50.00
51.00	05100	RECOVERY ROOM	2,846	0	1,366	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	363	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,650	0	5,329	0	0	54.00
60.00	06000	LABORATORY	1,667	0	3,940	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,449	0	3,606	0	0	65.00
66.00	06600	PHYSICAL THERAPY	920	0	1,867	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	394	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	218	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,511	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,479	0	4,929	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	963	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	4,227	0	3,647	17,070	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	678	0	1,064	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,654	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	629	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,938	99,747	39,776	69,882	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	66	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	119	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	537	0	0	194.01
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)	37,004	99,747	40,432	69,882	0	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	58,448					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,197				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,249	612,440	0	612,440	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	116	9,238	0	9,238	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,966	234,983	0	234,983	50.00
51.00	05100	RECOVERY ROOM	0	881	134,694	0	134,694	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	142	23,250	0	23,250	52.00
53.00	05300	ANESTHESIOLOGY	0	1,050	4,893	0	4,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,646	333,117	0	333,117	54.00
60.00	06000	LABORATORY	0	14,298	104,105	0	104,105	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,697	120,006	0	120,006	65.00
66.00	06600	PHYSICAL THERAPY	0	1,141	88,496	0	88,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	447	2,010	0	2,010	67.00
68.00	06800	SPEECH PATHOLOGY	0	120	979	0	979	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	773	5,571	0	5,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,448	8,399	66,847	0	66,847	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	452	69,866	0	69,866	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,119	224,384	0	224,384	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,243	43,134	0	43,134	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	143	2,692	0	2,692	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	462	30,455	0	30,455	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,591	101,308	0	101,308	88.05
91.00	09100	EMERGENCY	0	3,918	210,475	0	210,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	577	148,848	0	148,848	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,180	69,031	0	69,031	93.01
93.02	04040	INTERNAL MEDICINE	0	587	16,005	0	16,005	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,448	72,197	2,656,827	0	2,656,827	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	66	0	66	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	15,398	0	15,398	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	5,385	0	5,385	194.00
194.01	07951	LTC/WELLNESS	0	0	1,895	0	1,895	194.01
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)	58,448	72,197	2,679,571	0	2,679,571	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	106,705					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	22,918		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	126	0	0	0	26,824,697	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,302	400	600	16	4,105,132	5.00
7.00	00700	OPERATION OF PLANT	10,500	240	684	4,657	496,663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321	0	0	0	30,354	8.00
9.00	00900	HOUSEKEEPING	1,171	0	0	43	391,400	9.00
10.00	01000	DIETARY	3,872	0	0	0	158,852	10.00
11.00	01100	CAFETERIA	1,462	0	0	0	321,643	11.00
13.00	01300	NURSING ADMINISTRATION	2,553	0	0	0	560,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,386	0	0	0	375,468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	376	0	0	4,249	401,268	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,089	0	0	0	1,744,308	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	187	0	0	0	413,826	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,116	0	0	0	720,092	50.00
51.00	05100	RECOVERY ROOM	4,937	0	0	0	481,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	859	0	0	0	130,306	52.00
53.00	05300	ANESTHESIOLOGY	137	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,396	0	0	0	1,686,002	54.00
60.00	06000	LABORATORY	2,623	0	0	0	967,326	60.00
65.00	06500	RESPIRATORY THERAPY	4,062	0	0	0	1,127,610	65.00
66.00	06600	PHYSICAL THERAPY	3,151	0	0	0	616,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	169,934	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	82,233	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,634	437,027	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,677	0	0	0	2,597,017	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,504	1,550,921	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	194,691	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,860	0	0	711,787	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	6,216	0	1,304,190	88.05
91.00	09100	EMERGENCY	6,258	0	0	0	1,359,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	5,723	0	0	0	1,245,693	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	5,815	1,443,298	93.01
93.02	04040	INTERNAL MEDICINE	542	0	0	0	787,980	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,826	3,500	7,500	22,918	26,612,352	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	682	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	197	0	0	0	44,823	194.00
194.01	07951	LTC/WELLNESS	0	0	0	0	167,522	194.01
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)	2,394,851	19,986	80,898	183,836	1,192,199	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.443662	5.710286	10.786400	8.021468	0.044444	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					2,828	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000105	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:26 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.02	1.03	1.04	4.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 7:26 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,621,639	44,071,586				5.00
7.00	00700	OPERATION OF PLANT	0	3,355,003	111,219			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	176,551	321	1,205		8.00
9.00	00900	HOUSEKEEPING	0	615,995	1,214	444	175,297	9.00
10.00	01000	DIETARY	0	344,140	3,872	31	150	10.00
11.00	01100	CAFETERIA	0	488,450	1,462	0	3,325	11.00
13.00	01300	NURSING ADMINISTRATION	0	722,487	2,553	0	130	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,732,952	1,386	0	1,255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,433,861	4,625	0	980	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,988,415	17,089	176	42,348	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	539,435	187	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,611,826	8,116	25	22,370	50.00
51.00	05100	RECOVERY ROOM	0	790,885	4,937	83	13,480	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	187,815	859	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	66,356	137	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,044,233	11,396	192	17,290	54.00
60.00	06000	LABORATORY	0	3,034,980	2,623	0	7,895	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,475,170	4,062	19	6,865	65.00
66.00	06600	PHYSICAL THERAPY	0	865,494	3,151	9	4,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,903	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	105,930	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	804,113	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,235,870	5,634	0	7,160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,594,799	7,677	0	11,745	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,487,961	2,504	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	262,394	0	0	4,560	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	953,315	2,860	18	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	2,607,164	6,216	14	0	88.05
91.00	09100	EMERGENCY	0	3,780,628	6,258	194	20,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	405,879	5,723	0	3,210	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	606,465	5,815	0	7,835	93.01
93.02	04040	INTERNAL MEDICINE	0	179,520	542	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,621,639	43,690,989	111,219	1,205	174,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	315	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	15,307	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	140,802	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	224,488	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		8,621,639	4,011,336	222,667	862,332	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.195628	36.067003	184.785892	4.919263	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		262,981	301,833	9,131	37,004	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005967	2.713862	7.577593	0.211093	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

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		Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,917					10.00
11.00	01100	CAFETERIA	0	16,718				11.00
13.00	01300	NURSING ADMINISTRATION	0	520	85,785			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	414	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	738	8,020	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,917	2,050	56,810	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	478	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	937	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	565	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	150	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,204	0	0	0	54.00
60.00	06000	LABORATORY	0	1,629	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,491	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	772	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	163	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	90	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,038	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	0	1,508	20,955	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	440	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	260	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,917	16,447	85,785	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	49	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	222	0	0	0	194.01
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)	557,580	653,091	976,859	0	4,535,558	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	290.860720	39.065139	11.387294	0.000000	45,355.580000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	99,747	40,432	69,882	0	58,448	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	52.032864	2.418471	0.814618	0.000000	584.480000	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

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		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	AKRON BUILDING			1.02
1.03	00103	ARGOS BUILDING			1.03
1.04	00101	CLAYS BUILDING			1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,716,803		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,865,690		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	279,770		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	19,288,392		50.00
51.00	05100	RECOVERY ROOM	2,134,039		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	343,859		52.00
53.00	05300	ANESTHESIOLOGY	2,543,542		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,631,080		54.00
60.00	06000	LABORATORY	34,619,087		60.00
65.00	06500	RESPIRATORY THERAPY	8,951,318		65.00
66.00	06600	PHYSICAL THERAPY	2,763,687		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,081,526		67.00
68.00	06800	SPEECH PATHOLOGY	291,559		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,872,611		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,336,967		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,094,644		88.00
88.01	08801	RURAL HEALTH CLINIC II	5,131,230		88.01
88.02	08802	RURAL HEALTH CLINIC III	3,009,424		88.02
88.03	08803	RURAL HEALTH CLINIC IV	345,860		88.03
88.04	08804	RURAL HEALTH CLINIC V	1,117,564		88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,853,339		88.05
91.00	09100	EMERGENCY	9,485,839		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,396,854		93.00
93.01	04951	SHAFER MEDICAL CENTER	2,857,282		93.01
93.02	04040	INTERNAL MEDICINE	1,421,640		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,716,803		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
192.01	19201	FCMC	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0		192.03
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	ADVERTISING	0		194.00
194.01	07951	LTC/WELLNESS	0		194.01
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)	2,006,151		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011482		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,197		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000413		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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 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	5,805,112		5,805,112	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	673,594		673,594	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,788,229		3,788,229	0	0	50.00
51.00	05100	RECOVERY ROOM	1,251,891		1,251,891	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	265,347		265,347	0	0	52.00
53.00	05300	ANESTHESIOLOGY	113,483		113,483	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,746,966		4,746,966	0	0	54.00
60.00	06000	LABORATORY	4,223,282		4,223,282	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,108,566	0	2,108,566	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,233,458	0	1,233,458	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,426	0	249,426	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	133,517	0	133,517	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	982,921		982,921	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,769,067		4,769,067	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,728,633		1,728,633	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,771,237		4,771,237	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,099,542		3,099,542	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	340,129		340,129	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,259,120		1,259,120	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,388,221		3,388,221	0	0	88.05
91.00	09100	EMERGENCY	5,286,733		5,286,733	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,200,929		2,200,929		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	740,710		740,710	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,006,186		1,006,186	0	0	93.01
93.02	04040	INTERNAL MEDICINE	260,667		260,667	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	54,426,966	0	54,426,966	0	0	200.00
201.00		Less Observation Beds	2,200,929		2,200,929		0	201.00
202.00		Total (see instructions)	52,226,037	0	52,226,037	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 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	2,591,914		2,591,914			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	279,770		279,770			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,588,164	16,700,228	19,288,392	0.196399	0.000000	50.00
51.00	05100	RECOVERY ROOM	259,394	1,874,645	2,134,039	0.586630	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	223,331	120,528	343,859	0.771674	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	175,470	2,368,072	2,543,542	0.044616	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	687,467	41,943,613	42,631,080	0.111350	0.000000	54.00
60.00	06000	LABORATORY	1,591,108	33,027,979	34,619,087	0.121993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	764,900	8,186,418	8,951,318	0.235559	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	229,885	2,533,802	2,763,687	0.446309	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,744	953,782	1,081,526	0.230624	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,108	267,451	291,559	0.457942	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	451,989	1,420,622	1,872,611	0.524893	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,649	18,618,318	20,336,967	0.234502	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,094,644	1,094,644			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,131,230	5,131,230			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,009,424	3,009,424			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	345,860	345,860			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,117,564	1,117,564			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	3,853,339	3,853,339			88.05
91.00	09100	EMERGENCY	143,027	9,342,812	9,485,839	0.557329	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	294,716	4,979,060	5,273,776	0.417335	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,396,854	1,396,854	0.530270	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	2,857,282	2,857,282	0.352148	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,421,640	1,421,640	0.183357	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,151,636	162,565,167	174,716,803			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,151,636	162,565,167	174,716,803			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 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
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 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	5,805,112		5,805,112	0	5,805,112	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	673,594		673,594	0	673,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,788,229		3,788,229	0	3,788,229	50.00
51.00	05100	RECOVERY ROOM	1,251,891		1,251,891	0	1,251,891	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	265,347		265,347	0	265,347	52.00
53.00	05300	ANESTHESIOLOGY	113,483		113,483	0	113,483	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,746,966		4,746,966	0	4,746,966	54.00
60.00	06000	LABORATORY	4,223,282		4,223,282	0	4,223,282	60.00
65.00	06500	RESPIRATORY THERAPY	2,108,566	0	2,108,566	0	2,108,566	65.00
66.00	06600	PHYSICAL THERAPY	1,233,458	0	1,233,458	0	1,233,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,426	0	249,426	0	249,426	67.00
68.00	06800	SPEECH PATHOLOGY	133,517	0	133,517	0	133,517	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	982,921		982,921	0	982,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,769,067		4,769,067	0	4,769,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,728,633		1,728,633	0	1,728,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,771,237		4,771,237	0	4,771,237	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,099,542		3,099,542	0	3,099,542	88.02
88.03	08803	RURAL HEALTH CLINIC IV	340,129		340,129	0	340,129	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,259,120		1,259,120	0	1,259,120	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,388,221		3,388,221	0	3,388,221	88.05
91.00	09100	EMERGENCY	5,286,733		5,286,733	0	5,286,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,200,929		2,200,929		2,200,929	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	740,710		740,710	0	740,710	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,006,186		1,006,186	0	1,006,186	93.01
93.02	04040	INTERNAL MEDICINE	260,667		260,667	0	260,667	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	54,426,966	0	54,426,966	0	54,426,966	200.00
201.00		Less Observation Beds	2,200,929		2,200,929		2,200,929	201.00
202.00		Total (see instructions)	52,226,037	0	52,226,037	0	52,226,037	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 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	2,591,914		2,591,914			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	279,770		279,770			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,588,164	16,700,228	19,288,392	0.196399	0.000000	50.00
51.00	05100	RECOVERY ROOM	259,394	1,874,645	2,134,039	0.586630	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	223,331	120,528	343,859	0.771674	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	175,470	2,368,072	2,543,542	0.044616	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	687,467	41,943,613	42,631,080	0.111350	0.000000	54.00
60.00	06000	LABORATORY	1,591,108	33,027,979	34,619,087	0.121993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	764,900	8,186,418	8,951,318	0.235559	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	229,885	2,533,802	2,763,687	0.446309	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,744	953,782	1,081,526	0.230624	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,108	267,451	291,559	0.457942	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	451,989	1,420,622	1,872,611	0.524893	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,649	18,618,318	20,336,967	0.234502	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,094,644	1,094,644	1.579174	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,131,230	5,131,230	0.929843	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,009,424	3,009,424	1.029945	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	345,860	345,860	0.983430	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,117,564	1,117,564	1.126665	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	3,853,339	3,853,339	0.879295	0.000000	88.05
91.00	09100	EMERGENCY	143,027	9,342,812	9,485,839	0.557329	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	294,716	4,979,060	5,273,776	0.417335	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,396,854	1,396,854	0.530270	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	2,857,282	2,857,282	0.352148	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,421,640	1,421,640	0.183357	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,151,636	162,565,167	174,716,803			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,151,636	162,565,167	174,716,803			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 7:26 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	234,983	19,288,392	0.012183	517,934	6,310	50.00
51.00	05100	RECOVERY ROOM	134,694	2,134,039	0.063117	53,529	3,379	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,250	343,859	0.067615	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,893	2,543,542	0.001924	36,160	70	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	333,117	42,631,080	0.007814	229,148	1,791	54.00
60.00	06000	LABORATORY	104,105	34,619,087	0.003007	410,744	1,235	60.00
65.00	06500	RESPIRATORY THERAPY	120,006	8,951,318	0.013407	255,486	3,425	65.00
66.00	06600	PHYSICAL THERAPY	88,496	2,763,687	0.032021	62,053	1,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,010	1,081,526	0.001858	22,845	42	67.00
68.00	06800	SPEECH PATHOLOGY	979	291,559	0.003358	6,034	20	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,571	1,872,611	0.002975	153,294	456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,847	20,336,967	0.003287	397,328	1,306	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,866	1,094,644	0.063825	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	224,384	5,131,230	0.043729	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	43,134	3,009,424	0.014333	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,692	345,860	0.007783	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	30,455	1,117,564	0.027251	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	101,308	3,853,339	0.026291	0	0	88.05
91.00	09100	EMERGENCY	210,475	9,485,839	0.022188	29,439	653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	232,198	5,273,776	0.044029	28,741	1,265	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	148,848	1,396,854	0.106559	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	69,031	2,857,282	0.024160	0	0	93.01
93.02	04040	INTERNAL MEDICINE	16,005	1,421,640	0.011258	0	0	93.02
200.00		Total (lines 50 through 199)	2,267,347	171,845,119		2,202,735	21,939	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 7:26 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
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	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	0	0	93.02
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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 7:26 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	19,288,392	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,134,039	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	343,859	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,543,542	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,631,080	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	34,619,087	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,951,318	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,763,687	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,081,526	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	291,559	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,872,611	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,336,967	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,094,644	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	5,131,230	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	3,009,424	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	345,860	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,117,564	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	3,853,339	0.000000	88.05
91.00	09100	EMERGENCY	0	0	0	9,485,839	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,273,776	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,396,854	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	2,857,282	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	1,421,640	0.000000	93.02
200.00		Total (lines 50 through 199)	0	0	0	171,845,119		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 7:26 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	517,934	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	53,529	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	36,160	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	229,148	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	410,744	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	255,486	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	62,053	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,845	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,034	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	153,294	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	397,328	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
91.00	09100	EMERGENCY	0.000000	29,439	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	28,741	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.000000	0	0	0	0	93.02
200.00		Total (lines 50 through 199)		2,202,735	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 7:26 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	0.196399	0	2,365,130	0	0	50.00
51.00	05100	RECOVERY ROOM	0.586630	0	241,859	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.771674	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044616	0	410,086	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111350	0	7,703,328	0	0	54.00
60.00	06000	LABORATORY	0.121993	0	6,096,579	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.235559	0	1,712,342	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446309	0	635,039	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230624	0	168,499	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.457942	0	24,139	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524893	0	282,638	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234502	0	6,110,904	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
91.00	09100	EMERGENCY	0.557329	0	1,292,015	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.417335	0	820,700	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.530270	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.352148	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.183357	0	0	0	0	93.02
200.00		Subtotal (see instructions)		0	27,863,258	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	27,863,258	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 7:26 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	464,509	0		50.00
51.00	05100	RECOVERY ROOM	141,882	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	18,296	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	857,766	0		54.00
60.00	06000	LABORATORY	743,740	0		60.00
65.00	06500	RESPIRATORY THERAPY	403,358	0		65.00
66.00	06600	PHYSICAL THERAPY	283,424	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,860	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,054	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,355	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,433,019	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
91.00	09100	EMERGENCY	720,077	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	342,507	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0		93.01
93.02	04040	INTERNAL MEDICINE	0	0		93.02
200.00		Subtotal (see instructions)	5,606,847	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,606,847	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:26 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)	2,763	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,452	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)	1,476	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	97	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	214	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)	487	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)	97	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,805,112	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)	56,992	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)	275,732	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,529,380	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)	5,529,380	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)	2,255.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,098,209	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)	1,098,209	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:26 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)	508,309	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,606,518	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)	218,740	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	218,740	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)	976	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,255.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,200,929	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	612,440	5,805,112	0.105500	2,200,929	232,198	90.00
91.00	Nursing Program cost	0	5,805,112	0.000000	2,200,929	0	91.00
92.00	Allied health cost	0	5,805,112	0.000000	2,200,929	0	92.00
93.00	All other Medical Education	0	5,805,112	0.000000	2,200,929	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:26 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)	2,763	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,452	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)	1,476	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	97	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	214	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)	47	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)	334	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,805,112	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)	56,992	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)	275,732	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,529,380	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)	5,529,380	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)	2,255.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	105,987	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)	105,987	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 7:26 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)	673,594	334	2,016.75	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)	34,737	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)	140,724	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)	976	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,255.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 7:26 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,200,929	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	612,440	5,805,112	0.105500	2,200,929	232,198	90.00
91.00	Nursing Program cost	0	5,805,112	0.000000	2,200,929	0	91.00
92.00	Allied health cost	0	5,805,112	0.000000	2,200,929	0	92.00
93.00	All other Medical Education	0	5,805,112	0.000000	2,200,929	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:26 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		728,492		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	0.196399	517,934	101,722	50.00
51.00	05100	RECOVERY ROOM	0.586630	53,529	31,402	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.771674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044616	36,160	1,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111350	229,148	25,516	54.00
60.00	06000	LABORATORY	0.121993	410,744	50,108	60.00
65.00	06500	RESPIRATORY THERAPY	0.235559	255,486	60,182	65.00
66.00	06600	PHYSICAL THERAPY	0.446309	62,053	27,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230624	22,845	5,269	67.00
68.00	06800	SPEECH PATHOLOGY	0.457942	6,034	2,763	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524893	153,294	80,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234502	397,328	93,174	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.557329	29,439	16,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.417335	28,741	11,995	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.530270	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.352148	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.183357	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,202,735	508,309	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,202,735		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:26 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	0.196399	0	0	50.00
51.00	05100	RECOVERY ROOM	0.586630	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.771674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044616	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111350	5,855	652	54.00
60.00	06000	LABORATORY	0.121993	5,826	711	60.00
65.00	06500	RESPIRATORY THERAPY	0.235559	4,000	942	65.00
66.00	06600	PHYSICAL THERAPY	0.446309	33,711	15,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230624	23,419	5,401	67.00
68.00	06800	SPEECH PATHOLOGY	0.457942	3,020	1,383	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524893	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234502	8,451	1,982	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.557329	6,944	3,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.417335	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.530270	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.352148	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.183357	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		91,226	29,987	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)		91,226		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 7:26 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		79,258		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196399	64,531	12,674	50.00
51.00	05100	RECOVERY ROOM	0.586630	7,402	4,342	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.771674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044616	4,681	209	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111350	9,186	1,023	54.00
60.00	06000	LABORATORY	0.121993	34,236	4,177	60.00
65.00	06500	RESPIRATORY THERAPY	0.235559	6,850	1,614	65.00
66.00	06600	PHYSICAL THERAPY	0.446309	567	253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230624	110	25	67.00
68.00	06800	SPEECH PATHOLOGY	0.457942	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524893	1,122	589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234502	32,076	7,522	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.579174	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.929843	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.029945	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.983430	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.126665	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.879295	0	0	88.05
91.00	09100	EMERGENCY	0.557329	4,143	2,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.417335	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.530270	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.352148	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.183357	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		164,904	34,737	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)		164,904		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,606,847	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)	5,606,847	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)	5,662,915	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)	79,749	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,341,887	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)	1,241,279	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)	1,241,279	30.00
31.00	Primary payer payments	218	31.00
32.00	Subtotal (line 30 minus line 31)	1,241,061	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)	358,452	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	232,994	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	295,393	36.00
37.00	Subtotal (see instructions)	1,474,055	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,474,055	40.00
40.01	Sequestration adjustment (see instructions)	29,481	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	1,946,137	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)	-501,563	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: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 7:26 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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 7:26 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		1,223,575		1,946,137	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,223,575		1,946,137	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		189,603		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		501,563	6.02
7.00	Total Medicare program liability (see instructions)		1,413,178		1,444,574	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: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 7:26 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		189,471		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		189,471		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		56,131		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		245,602		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 7:26 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)	220,927	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)	30,287	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	97	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)	251,214	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	251,214	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)	251,214	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	250,614	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)	250,614	0	19.00
19.01	Sequestration adjustment (see instructions)	5,012	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	189,471	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)	56,131	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: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,606,518	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)	1,606,518	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,622,583	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)	1,622,583	19.00
20.00	Deductibles (exclude professional component)	193,325	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,429,258	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,429,258	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	19,631	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	12,760	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,468	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,442,018	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)	1,442,018	30.00
30.01	Sequestration adjustment (see instructions)	28,840	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,223,575	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)	189,603	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: 15-1313	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 7:26 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	140,724		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	140,724	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	140,724	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	79,258		8.00
9.00	Ancillary service charges	164,904	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	244,162	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	244,162	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	103,438	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	140,724	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	140,724	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	140,724	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	140,724	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	140,724	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)	140,724	0	40.00
41.00	Interim payments	155,902	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-15,178	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: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 7:26 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	10,780,400	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	22,047,543	0	0	0	4.00
5.00	Other receivable	1,365,063	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,222,212	0	0	0	6.00
7.00	Inventory	964,708	0	0	0	7.00
8.00	Prepaid expenses	238,243	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,173,745	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	830,661	0	0	0	13.00
14.00	Accumulated depreciation	-507,816	0	0	0	14.00
15.00	Buildings	31,256,833	0	0	0	15.00
16.00	Accumulated depreciation	-18,167,885	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,150,012	0	0	0	23.00
24.00	Accumulated depreciation	-13,381,834	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)	17,776,187	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	11,765,439	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	708,019	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,473,458	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,423,390	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,179,845	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,921,553	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	531,422	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,504,090	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,136,910	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,407,150	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)	7,407,150	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,544,060	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,879,330				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)	36,879,330	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,423,390	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 7:26 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		33,962,539		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,916,791				2.00
3.00	Total (sum of line 1 and line 2)		36,879,330		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		36,879,330		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)		36,879,330		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2024 7:26 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,277,175		3,277,175	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	53,750		53,750	5.00
6.00	Swing bed - NF	140,625		140,625	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,471,550		3,471,550	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)	3,471,550		3,471,550	17.00
18.00	Ancillary services	8,692,929	142,413,846	151,106,775	18.00
19.00	Outpatient services	0	22,477	22,477	19.00
20.00	RURAL HEALTH CLINIC	0	1,094,644	1,094,644	20.00
20.01	RURAL HEALTH CLINIC II	0	5,131,230	5,131,230	20.01
20.02	RURAL HEALTH CLINIC III	0	3,009,424	3,009,424	20.02
20.03	RURAL HEALTH CLINIC IV	0	345,860	345,860	20.03
20.04	RURAL HEALTH CLINIC V	0	1,117,564	1,117,564	20.04
20.05	RURAL HEALTH CLINIC VI	0	3,853,339	3,853,339	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	5,675,776	5,675,776	27.00
27.01	PROFESSIONAL FEES	0	4,095,908	4,095,908	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,164,479	166,760,068	178,924,547	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,318,210		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)		63,318,210		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/29/2024 7:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	178,924,547	1.00
2.00	Less contractual allowances and discounts on patients' accounts	120,267,912	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,656,635	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,318,210	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,661,575	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	671,517	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	140,252	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	4,340,372	24.00
24.01	LTC REVENUE	2,426,306	24.01
24.02	GAIN/LOSS DISP ASSET-MISC	-81	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,578,366	25.00
26.00	Total (line 5 plus line 25)	2,916,791	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)	2,916,791	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	4,250	4,250	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	163,119	0	163,119	65,139	228,258	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	48,659	0	48,659	0	48,659	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	80,557	0	80,557	0	80,557	9.00
10.00	Subtotal (sum of lines 1 through 9)	292,335	0	292,335	69,389	361,724	10.00
11.00	Physician Services Under Agreement	0	635,314	635,314	0	635,314	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	635,314	635,314	0	635,314	14.00
15.00	Medical Supplies	0	457	457	0	457	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	457	457	0	457	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	292,335	635,771	928,106	69,389	997,495	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,066	7,066	-53	7,013	29.00
30.00	Administrative Costs	56,609	117,820	174,429	18,694	193,123	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	56,609	124,886	181,495	18,641	200,136	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	348,944	760,657	1,109,601	88,030	1,197,631	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	4,250		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-26,377	201,881		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	48,659		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	80,557		9.00
10.00	Subtotal (sum of lines 1 through 9)	-26,377	335,347		10.00
11.00	Physician Services Under Agreement	0	635,314		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	635,314		14.00
15.00	Medical Supplies	0	457		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	457		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-26,377	971,118		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,013		29.00
30.00	Administrative Costs	0	193,123		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	200,136		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-26,377	1,171,254		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,983,070	19,352	2,002,422	0	2,002,422	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	237,587	0	237,587	0	237,587	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	215,954	0	215,954	0	215,954	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,436,611	19,352	2,455,963	0	2,455,963	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	437,554	437,554	0	437,554	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	437,554	437,554	0	437,554	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,436,611	456,906	2,893,517	0	2,893,517	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	663,792	663,792	-663,784	8	29.00
30.00	Administrative Costs	210,211	392,945	603,156	-49,805	553,351	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	210,211	1,056,737	1,266,948	-713,589	553,359	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,646,822	1,513,643	4,160,465	-713,589	3,446,876	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-136,246	1,866,176		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-3,553	234,034		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	215,954		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-139,799	2,316,164		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	437,554		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	437,554		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-139,799	2,753,718		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8		29.00
30.00	Administrative Costs	0	553,351		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	553,359		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-139,799	3,307,077		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,138,936	113,598	1,252,534	0	1,252,534	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	226,461	0	226,461	-69,389	157,072	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	67,767	0	67,767	0	67,767	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,433,164	113,598	1,546,762	-69,389	1,477,373	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	189,472	189,472	0	189,472	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	189,472	189,472	0	189,472	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,433,164	303,070	1,736,234	-69,389	1,666,845	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	198,989	198,989	-12,730	186,259	29.00
30.00	Administrative Costs	136,173	436,283	572,456	50,973	623,429	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	136,173	635,272	771,445	38,243	809,688	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,569,337	938,342	2,507,679	-31,146	2,476,533	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-68,034	1,184,500		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-9,553	147,519		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	67,767		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-77,587	1,399,786		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	189,472		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	189,472		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-77,587	1,589,258		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	186,259		29.00
30.00	Administrative Costs	0	623,429		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	809,688		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-77,587	2,398,946		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	149,423	4,525	153,948	0	153,948	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	22,136	0	22,136	0	22,136	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	978	0	978	0	978	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	172,537	4,525	177,062	0	177,062	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	5,155	5,155	0	5,155	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	5,155	5,155	0	5,155	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	172,537	9,680	182,217	0	182,217	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,473	6,473	12,730	19,203	29.00
30.00	Administrative Costs	15,866	30,167	46,033	6,288	52,321	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	15,866	36,640	52,506	19,018	71,524	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	188,403	46,320	234,723	19,018	253,741	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	153,948		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	22,136		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	978		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	177,062		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	5,155		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,155		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	182,217		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,203		29.00
30.00	Administrative Costs	0	52,321		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	71,524		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	253,741		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	491,896	13,247	505,143	0	505,143	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	152,036	0	152,036	0	152,036	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	643,932	13,247	657,179	0	657,179	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	30,951	30,951	0	30,951	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	30,951	30,951	0	30,951	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	643,932	44,198	688,130	0	688,130	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	21,133	21,133	0	21,133	29.00
30.00	Administrative Costs	61,755	165,720	227,475	-15,033	212,442	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,755	186,853	248,608	-15,033	233,575	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	705,687	231,051	936,738	-15,033	921,705	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-677	504,466		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-15,680	136,356		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-16,357	640,822		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	30,951		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,951		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-16,357	671,773		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	21,133		29.00
30.00	Administrative Costs	0	212,442		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	233,575		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-16,357	905,348		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	767,900	0	767,900	0	767,900	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	222,376	0	222,376	0	222,376	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	44,335	0	44,335	0	44,335	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,034,611	0	1,034,611	0	1,034,611	10.00
11.00	Physician Services Under Agreement	0	779,863	779,863	0	779,863	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	779,863	779,863	0	779,863	14.00
15.00	Medical Supplies	0	126,476	126,476	0	126,476	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	126,476	126,476	0	126,476	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,034,611	906,339	1,940,950	0	1,940,950	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	35,765	35,765	0	35,765	29.00
30.00	Administrative Costs	249,291	302,545	551,836	-15,477	536,359	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	249,291	338,310	587,601	-15,477	572,124	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,283,902	1,244,649	2,528,551	-15,477	2,513,074	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 7:26 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-16,032	751,868		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-14,889	207,487		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	44,335		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-30,921	1,003,690		10.00
11.00	Physician Services Under Agreement	0	779,863		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	779,863		14.00
15.00	Medical Supplies	0	126,476		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	126,476		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-30,921	1,910,029		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	35,765		29.00
30.00	Administrative Costs	0	536,359		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	572,124		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-30,921	2,482,153		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:26 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	17	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.07	1,328	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	1,345		1	1,345	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.08	1,345			1,345	8.00
9.00	Physician Services Under Agreements		4,124			4,124	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)	971,118	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	971,118	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	200,136	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	557,379	15.00
16.00	Total overhead (sum of lines 14 and 15)	757,515	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	757,515	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	757,515	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,728,633	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:26 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.66	14,256	4,200	15,372		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.51	5,143	2,100	3,171		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.17	19,399		18,543	19,399	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)	5.17	19,399			19,399	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)	2,753,718	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,753,718	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	553,359	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,464,160	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,017,519	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,017,519	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,017,519	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,771,237	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.94	12,405	4,200	8,148		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.59	2,168	2,100	1,239		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.53	14,573		9,387	14,573	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.53	14,573			14,573	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)	1,589,258	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,589,258	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	809,688	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	700,596	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,510,284	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,510,284	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,510,284	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,099,542	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:26 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.26	1,384	4,200	1,092		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.33	697	2,100	693		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.59	2,081		1,785	2,081	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.59	2,081			2,081	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)	182,217	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	182,217	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	71,524	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	86,388	15.00
16.00	Total overhead (sum of lines 14 and 15)	157,912	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	157,912	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	157,912	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	340,129	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 7:26 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.90	3,014	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.39	2,749	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.29	5,763		2	5,763	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.29	5,763			5,763	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)	671,773	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	671,773	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	233,575	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	353,772	15.00
16.00	Total overhead (sum of lines 14 and 15)	587,347	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	587,347	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	587,347	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,259,120	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313
Component CCN: 15-8548

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

Worksheet M-2
Date/Time Prepared: 5/29/2024 7:26 am

RHC VI — Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.53	4,585	4,200	2,226		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.56	7,915	2,100	3,276		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.09	12,500		5,502	12,500	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.09	12,500			12,500	8.00
9.00	Physician Services Under Agreements		6,667			6,667	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)	1,910,029	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,910,029	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	572,124	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	906,068	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,478,192	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,478,192	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,478,192	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,388,221	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,728,633	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	4,700	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,723,933	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1,345	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	4,124	5.00
6.00	Total adjusted visits (line 4 plus line 5)	5,469	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	315.22	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	279.94	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	279.94	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,292	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	361,682	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	361,682	16.00
16.01	Total program charges (see instructions)(from contractor's records)		217,044	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,831	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,717	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.)		265,712	16.04
16.05	Total program cost (see instructions)	0	270,429	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,825	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		37,854	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		270,429	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,967	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)		272,396	22.00
23.00	Allowable bad debts (see instructions)		466	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		303	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)		272,699	26.00
26.01	Sequestration adjustment (see instructions)		5,454	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		264,696	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)		2,549	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8552	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,771,237	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		104,200	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		4,667,037	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		19,399	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)		19,399	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		240.58	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	299.90	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	240.58	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	456	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	109,704	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	109,704	16.00
16.01	Total program charges (see instructions)(from contractor's records)		70,099	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,548	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,988	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.)		77,908	16.04
16.05	Total program cost (see instructions)	0	81,896	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,331	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,821	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		81,896	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		500	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)		82,396	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)		82,396	26.00
26.01	Sequestration adjustment (see instructions)		1,648	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		134,563	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)		-53,815	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8550	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC III	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	3,099,542	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	85,092	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	3,014,450	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	14,573	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)	14,573	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	206.85	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	221.05	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	206.85	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	474,928	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	474,928	16.00
16.01	Total program charges (see instructions)(from contractor's records)		345,772	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,242	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,200	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.)		340,019	16.04
16.05	Total program cost (see instructions)	0	347,219	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,704	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		59,565	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		347,219	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		25,982	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)		373,201	22.00
23.00	Allowable bad debts (see instructions)		884	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		575	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)		373,776	26.00
26.01	Sequestration adjustment (see instructions)		7,476	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		403,498	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)		-37,198	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8549	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		340,129	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		1,673	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		338,456	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,081	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,081	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		162.64	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	180.24	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	162.64	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	399	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	64,893	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	64,893	16.00
16.01	Total program charges (see instructions)(from contractor's records)		61,190	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		592	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		628	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.)		38,784	16.04
16.05	Total program cost (see instructions)	0	39,412	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,785	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,963	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		39,412	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		558	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)		39,970	22.00
23.00	Allowable bad debts (see instructions)		129	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		84	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)		40,054	26.00
26.01	Sequestration adjustment (see instructions)		801	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		66,404	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)		-27,151	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8547	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,259,120	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		22,564	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,236,556	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,763	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)		5,763	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		214.57	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	225.94	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	214.57	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	850	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	182,385	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	182,385	16.00
16.01	Total program charges (see instructions)(from contractor's records)		139,454	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,877	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,533	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.)		116,954	16.04
16.05	Total program cost (see instructions)	0	132,487	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,659	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,384	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		132,487	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,052	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)		138,539	22.00
23.00	Allowable bad debts (see instructions)		171	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		111	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)		138,650	26.00
26.01	Sequestration adjustment (see instructions)		2,773	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		175,021	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)		-39,144	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8548	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 7:26 am
	Title XVIII	RHC VI	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,388,221	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		108,834	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,279,387	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,500	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		6,667	5.00
6.00	Total adjusted visits (line 4 plus line 5)		19,167	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		171.10	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	176.29	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	171.10	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,363	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	404,309	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	404,309	16.00
16.01	Total program charges (see instructions)(from contractor's records)		383,741	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		32,935	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,700	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.)		256,855	16.04
16.05	Total program cost (see instructions)	0	291,555	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		48,540	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		60,453	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		291,555	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,611	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)		321,166	22.00
23.00	Allowable bad debts (see instructions)		240	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		156	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)		321,322	26.00
26.01	Sequestration adjustment (see instructions)		6,426	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		355,531	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)		-40,635	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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	335,347	335,347	335,347	335,347	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.003220	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	1,080	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,560	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	2,640	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	971,118	971,118	971,118	971,118	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	757,515	757,515	757,515	757,515	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.002719	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,060	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	4,700	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	43	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	109.30	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	18	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,967	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)		4,700	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)		1,967	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,316,164	2,316,164	2,316,164	2,316,164	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001472	0.007811	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,409	18,092	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	20,354	18,285	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	23,763	36,377	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,753,718	2,753,718	2,753,718	2,753,718	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,017,519	2,017,519	2,017,519	2,017,519	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008629	0.013210	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,409	26,651	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	41,172	63,028	0	0	10.00
11.00	Total number of injections/infusions (from your records)	95	504	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	433.39	125.06	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	4	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	500	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)		104,200	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)		500	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,399,786	1,399,786	1,399,786	1,399,786	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000792	0.014602	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,109	20,440	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,356	16,725	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,465	37,165	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,589,258	1,589,258	1,589,258	1,589,258	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,510,284	1,510,284	1,510,284	1,510,284	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004068	0.023385	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,144	35,318	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12,609	72,483	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	461	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	504.36	157.23	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	146	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,026	22,956	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)		85,092	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)		25,982	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	177,062	177,062	177,062	177,062	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000407	0.000407	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	72	72	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	643	109	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	715	181	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	182,217	182,217	182,217	182,217	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	157,912	157,912	157,912	157,912	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003924	0.000993	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	620	157	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,335	338	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	3	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	445.00	112.67	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	1	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)	445	113	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)		1,673	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)		558	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	640,822	640,822	640,822	640,822	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000070	0.006893	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	45	4,417	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	429	7,147	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	474	11,564	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	671,773	671,773	671,773	671,773	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	587,347	587,347	587,347	587,347	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000706	0.017214	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	415	10,111	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	889	21,675	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	197	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	444.50	110.03	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	55	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	6,052	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)		22,564	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6,052	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 7:26 am

Title XVIII | RHC VI | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,003,690	1,003,690	1,003,690	1,003,690	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003489	0.019669	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,502	19,742	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	19,497	18,612	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	22,999	38,354	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,910,029	1,910,029	1,910,029	1,910,029	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,478,192	1,478,192	1,478,192	1,478,192	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012041	0.020080	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,799	29,682	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	40,798	68,036	0	0	10.00
11.00	Total number of injections/infusions (from your records)	91	513	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	448.33	132.62	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	27	132	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)	12,105	17,506	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)		108,834	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)		29,611	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		264,696	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)		264,696	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		2,549	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		267,245	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8552	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		134,563	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)		134,563	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		53,815	6.02
7.00	Total Medicare program liability (see instructions)		80,748	7.00

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

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

Provider CCN: 15-1313
Component CCN: 15-8550

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

Worksheet M-5

Date/Time Prepared: 5/29/2024 7:26 am

RHC III | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		403,498	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)		403,498	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		37,198	6.02
7.00	Total Medicare program liability (see instructions)		366,300	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8549	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		66,404	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)		66,404	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		27,151	6.02
7.00	Total Medicare program liability (see instructions)		39,253	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8547	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		175,021	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		175,021	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		39,144	6.02
7.00	Total Medicare program liability (see instructions)		135,877	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8548	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		355,531	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)		355,531	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		40,635	6.02
7.00	Total Medicare program liability (see instructions)		314,896	7.00

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