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: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 2:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 2:41 pm
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 DEACONESS GIBSON (15-1319) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Lois Morgan		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	Lois Morgan			2
3	Signatory Title	CAO			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	-32,153	-652,330	0	17,392	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	104,360	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		3,452		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-12,558		0	10.01
200.00	TOTAL	0	72,207	-661,435	0	17,392	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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	DEACONESS GIBSON	151319	99915	1	12/16/2003	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	GIBSON GENERAL SWING BED	15Z319	99915		12/16/2003	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	GIBSON HOME HEALTH	157445	99915		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GIBSON GENERAL FAMILY MEDICINE FORT	158524	99915		09/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIBSON GENERAL FAMILY MEDICINE- 510	158553	99915		05/29/2019	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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

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

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

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

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

			V	XIX	
			1.00	2.00	
	Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	24,297	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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 2:41 pm

		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	02/01/2024	Y	02/01/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AUSTIN		FISHER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-275-7438		AFISHER@BLUEANDCO.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 2:41 pm

	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	11,448.00	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	11,448.00	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						13.00
14.00	Total (see instructions)		25	9,125	11,448.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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
26.25	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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

	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)	201	6	477			1.00
2.00	HMO and other (see instructions)	155	39				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	889	0	889			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	923			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,090	6	2,289			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						13.00
14.00	Total (see instructions)	1,090	6	2,289	0.00	146.73	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,880	21	6,221	0.00	6.21	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	136	0	1,579	0.00	4.03	26.00
26.01	RURAL HEALTH CLINIC II	1,049	0	6,601	0.00	6.19	26.01
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	163.16	27.00
28.00	Observation Bed Days		193	1,033			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

	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	69	2	161	1.00
2.00	HMO and other (see instructions)			47	14		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	69	2	161	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-4 | Date/Time Prepared: 2/27/2024 2:41 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	151.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.95	0.00	0.95	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			2.17	0.00	2.17	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.64	0.00	1.64	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.06	0.00	1.06	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.08	0.00	0.08	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.30	0.00	0.30	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99915	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,330	326	29	7	1,692	21.00
22.00	Skilled Nursing Visit Charges	214,049	52,587	4,694	1,130	272,460	22.00
23.00	Physical Therapy Visits	784	489	3	7	1,283	23.00
24.00	Physical Therapy Visit Charges	138,301	86,225	535	1,228	226,289	24.00
25.00	Occupational Therapy Visits	363	400	1	4	768	25.00
26.00	Occupational Therapy Visit Charges	64,394	70,776	180	705	136,055	26.00
27.00	Speech Pathology Visits	26	41	0	0	67	27.00
28.00	Speech Pathology Visit Charges	4,998	7,848	0	0	12,846	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	63	7	0	0	70	31.00
32.00	Home Health Aide Visit Charges	4,536	503	0	0	5,039	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,566	1,263	33	18	3,880	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	426,278	217,939	5,409	3,063	652,689	35.00
36.00	Total Number of Episodes (standard/non outlier)	266		26	2	294	36.00
37.00	Total Number of Outlier Episodes		68		1	69	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7851 S. PROFESSIONAL DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FORT BRANCH		IN	47648	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1319
Component CCN: 15-8524

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

Worksheet S-8
Date/Time Prepared:
2/27/2024 2:41 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			510 N MAIN ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IN	47670	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1319
Component CCN: 15-8553

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

Worksheet S-8
Date/Time Prepared:
2/27/2024 2:41 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 2:41 pm

		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)	0.414159	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,360,359	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	842,200	5.00
6.00	Medicaid charges	14,308,966	6.00
7.00	Medicaid cost (line 1 times line 6)	5,926,187	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,221,160	629,482	1,850,642	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	505,754	629,482	1,135,236	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)	505,754	629,482	1,135,236	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)	348,182	26.00
27.00	Medicare reimbursable bad debts (see instructions)	176,027	27.00
27.01	Medicare allowable bad debts (see instructions)	270,811	27.01
28.00	Non-Medicare bad debt amount (see instructions)	77,371	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	126,828	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,262,064	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,262,064	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 2:41 pm

				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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 2:41 pm

		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		2,011,349	2,011,349	402,195	2,413,544	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,284	1,668,391	1,687,675	32,207	1,719,882	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	908,496	6,069,223	6,977,719	227,426	7,205,145	5.00
7.00	00700	OPERATION OF PLANT	214,165	1,175,336	1,389,501	150,090	1,539,591	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,240	16,404	84,644	-1,087	83,557	8.00
9.00	00900	HOUSEKEEPING	318,324	106,797	425,121	-13,279	411,842	9.00
10.00	01000	DIETARY	410,920	267,766	678,686	-501,858	176,828	10.00
11.00	01100	CAFETERIA	0	0	0	498,361	498,361	11.00
13.00	01300	NURSING ADMINISTRATION	124,932	22,447	147,379	-1,994	145,385	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	170,972	-123,995	46,977	21,694	68,671	14.00
15.00	01500	PHARMACY	230,179	3,172,310	3,402,489	207,377	3,609,866	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,418	31,546	125,964	-1	125,963	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,323,721	1,338,198	3,661,919	-223,408	3,438,511	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,387,965	1,464,187	2,852,152	-217,716	2,634,436	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,585	741,039	1,950,624	-72,016	1,878,608	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	167,397	167,397	-162	167,235	54.03
60.00	06000	LABORATORY	1,011,071	2,081,753	3,092,824	-147,048	2,945,776	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	49,867	49,867	-1,159	48,708	62.00
65.00	06500	RESPIRATORY THERAPY	550,786	554,996	1,105,782	-11,716	1,094,066	65.00
66.00	06600	PHYSICAL THERAPY	0	2,112,269	2,112,269	-19,984	2,092,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	243,900	243,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	267,636	267,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	130,019	130,019	-526	129,493	73.00
76.00	03480	INFUSION THERAPY	163,159	82,561	245,720	-5,530	240,190	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	311,366	340,317	651,683	-34,676	617,007	88.00
88.01	08801	RURAL HEALTH CLINIC II	600,086	391,327	991,413	-112,386	879,027	88.01
90.00	09000	CLINIC	110,880	200,756	311,636	-29,514	282,122	90.00
90.01	09001	DIABETES	0	35	35	0	35	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	145,986	152,075	298,061	-3,529	294,532	90.03
91.00	09100	EMERGENCY	1,463,926	2,173,940	3,637,866	-79,858	3,558,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	570,992	395,539	966,531	-46,173	920,358	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		402,195	402,195	-402,195	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,409,453	27,196,044	39,605,497	125,071	39,730,568	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,640,699	1,469,107	3,109,806	-125,071	2,984,735	194.00
194.01	07951	FOUNDATION	0	12	12	0	12	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	14,050,152	28,665,163	42,715,315	0	42,715,315	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 2:41 pm

		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	-402,195	2,011,349		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,090,505	2,810,387		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	495,006	7,700,151		5.00
7.00	00700	OPERATION OF PLANT	428,400	1,967,991		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,557		8.00
9.00	00900	HOUSEKEEPING	184,957	596,799		9.00
10.00	01000	DIETARY	106,050	282,878		10.00
11.00	01100	CAFETERIA	-145,420	352,941		11.00
13.00	01300	NURSING ADMINISTRATION	54,291	199,676		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-31,553	37,118		14.00
15.00	01500	PHARMACY	233,843	3,843,709		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,592	128,555		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-57,452	3,381,059		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-626,715	2,007,721		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,804	1,869,804		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	167,235		54.03
60.00	06000	LABORATORY	-20,826	2,924,950		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	48,708		62.00
65.00	06500	RESPIRATORY THERAPY	-323,650	770,416		65.00
66.00	06600	PHYSICAL THERAPY	-113	2,092,172		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	243,900		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	267,636		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-130,019	-526		73.00
76.00	03480	INFUSION THERAPY	0	240,190		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-26,426	590,581		88.00
88.01	08801	RURAL HEALTH CLINIC II	-44,629	834,398		88.01
90.00	09000	CLINIC	0	282,122		90.00
90.01	09001	DIABETES	0	35		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	-134,238	160,294		90.03
91.00	09100	EMERGENCY	0	3,558,008		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,440	918,918		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	642,164	40,372,732		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	-60,960	2,923,775		194.00
194.01	07951	FOUNDATION	0	12		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	581,204	43,296,519		200.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 2:41 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	301,740	196,621	1.00
	0		301,740	196,621	
	B - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	243,900	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	267,636	2.00
3.00	CENTRAL SERVICE & SUPPLY	14.00	0	21,694	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
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	533,230	
	C - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	10,880	7,592	1.00
	0		10,880	7,592	
	D - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	402,195	1.00
	0		0	402,195	
	E - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	100,320	71,578	1.00
	0		100,320	71,578	
	F - HEALTH INSURANCE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,184	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
	0		0	15,184	
	G - MALPRACTICE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,297	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	24,297	
	H - MOB COLLECTION EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	585	1.00
	0		0	585	
	I - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	130,549	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
	0		0	130,549	
	J - MAINTENANCE RECLASS				
1.00	OPERATION OF PLANT	7.00	0	19,635	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

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 2:41 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	19,635		
	K - PTO ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	677	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	2,359	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	1,405	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	165	0		4.00
5.00	PAIN MANAGEMENT	90.03	4,008	0		5.00
	0		8,614	0		
	L - BILLING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,275		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	79,275		
	M - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	234,620		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	234,620		
500.00	Grand Total: Increases		421,554	1,715,361		500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 2:41 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	301,740	196,621	0		1.00
	0		301,740	196,621			
	B - MED SUPPLY CHG PTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	865	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	932	0		2.00
3.00	OPERATION OF PLANT	7.00	0	94	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,087	0		4.00
5.00	HOUSEKEEPING	9.00	0	1,936	0		5.00
6.00	DIETARY	10.00	0	832	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	298	0		7.00
8.00	PHARMACY	15.00	0	22,913	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	42,602	0		10.00
11.00	OPERATING ROOM	50.00	0	154,961	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,371	0		12.00
13.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.03	0	162	0		13.00
14.00	LABORATORY	60.00	0	147,048	0		14.00
15.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1,159	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	7,156	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	3,204	0		17.00
18.00	INFUSION THERAPY	76.00	0	5,184	0		18.00
19.00	RURAL HEALTH CLINIC	88.00	0	2,412	0		19.00
20.00	RURAL HEALTH CLINIC II	88.01	0	11,056	0		20.00
21.00	CLINIC	90.00	0	29,262	0		21.00
22.00	PAIN MANAGEMENT	90.03	0	34	0		22.00
23.00	EMERGENCY	91.00	0	76,762	0		23.00
24.00	HOME HEALTH AGENCY	101.00	0	3,623	0		24.00
25.00	MOB	194.00	0	3,276	0		25.00
	0		0	533,230			
	C - BUSINESS HEALTH SER						
1.00	MOB	194.00	10,880	7,592	0		1.00
	0		10,880	7,592			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	402,195	10		1.00
	0		0	402,195			
	E - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	100,320	71,578	0		1.00
	0		100,320	71,578			
	F - HEALTH INSURANCE						
1.00	NURSING ADMINISTRATION	13.00	0	1,696	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	1,052	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	4,048	0		3.00
4.00	MOB	194.00	0	8,354	0		4.00
5.00	OPERATING ROOM	50.00	0	34	0		5.00
	0		0	15,184			
	G - MALPRACTICE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	4,895	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	10,247	0		2.00
3.00	MOB	194.00	0	9,155	0		3.00
	0		0	24,297			
	H - MOB COLLECTION EXPENSE						
1.00	OPERATING ROOM	50.00	0	585	0		1.00
	0		0	585			
	I - UTILITIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,969	0		1.00
2.00	HOUSEKEEPING	9.00	0	11,343	0		2.00
3.00	DIETARY	10.00	0	120	0		3.00
4.00	PHARMACY	15.00	0	4,301	0		4.00
5.00	OPERATING ROOM	50.00	0	47,312	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	12,959	0		6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	7,545	0		7.00
	0		0	130,549			
	J - MAINTENANCE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	584	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	728	0		2.00
3.00	DIETARY	10.00	0	1,381	0		3.00
4.00	PHARMACY	15.00	0	29	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,131	0		5.00
6.00	OPERATING ROOM	50.00	0	7,015	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,048	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	175	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	2,775	0		9.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 2:41 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
10.00	MOB	194.00	0	3,769	0		10.00
	0		0	19,635			
	K - PTO ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	677	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,359	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,405	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	165	0		4.00
5.00	PAIN MANAGEMENT	90.03	0	4,008	0		5.00
	0		0	8,614			
	L - BILLING RECLASS						
1.00	HOME HEALTH AGENCY	101.00	0	42,547	0		1.00
2.00	MOB	194.00		36,728	0		2.00
	TOTALS		0	79,275			
	M - DRUGS RECLASS						
1.00	DIETARY	10.00	0	1,164	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,777	0		2.00
3.00	OPERATING ROOM	50.00	0	7,809	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,597	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	4,385	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1,046	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	526	0		7.00
8.00	INFUSION THERAPY	76.00	0	346	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	26,317	0		9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	79,490	0		10.00
11.00	CLINIC	90.00	0	252	0		11.00
12.00	PAIN MANAGEMENT	90.03	0	3,495	0		12.00
13.00	EMERGENCY	91.00	0	3,096	0		13.00
14.00	HOME HEALTH AGENCY	101.00	0	3	0		14.00
15.00	MOB	194.00	0	45,317	0		15.00
	TOTALS		0	234,620			
500.00	Grand Total: Decreases		412,940	1,723,975			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

		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	421,244	0	0	0	0	1.00
2.00	Land Improvements	7,898,966	136,700	0	136,700	0	2.00
3.00	Buildings and Fixtures	1,098,593	603,567	0	603,567	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,245,407	647,973	0	647,973	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,664,210	1,388,240	0	1,388,240	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,664,210	1,388,240	0	1,388,240	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	421,244	0	1.00
2.00	Land Improvements	8,035,666	0	2.00
3.00	Buildings and Fixtures	1,702,160	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	9,893,380	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,052,450	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,052,450	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2024 2:41 pm

	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	1,694,931	0	0	316,418	0	1.00
3.00	Total (sum of lines 1-2)	1,694,931	0	0	316,418	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,011,349		1.00
3.00	Total (sum of lines 1-2)	0	2,011,349		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2024 2:41 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	20,052,450	0	20,052,450	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	20,052,450	0	20,052,450	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	1,694,931	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,694,931	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	0	316,418	0	0	2,011,349	1.00
3.00	Total (sum of lines 1-2)	0	316,418	0	0	2,011,349	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 2:41 pm

	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	-402,195	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-322	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,371	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-125	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-967,645			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	3,568,558			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-145,420	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	-4,712	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 2:41 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-42,146	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.03	MISC INCOME	B	-1,404	RESPIRATORY THERAPY	65.00	0	33.03
33.04	MISC INCOME	B	-113	PHYSICAL THERAPY	66.00	0	33.04
33.05	PHYSICIAN RECRUITING	A	-369	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HAF FEE	A	-1,389	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HAF FEE	A	-1,269,639	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING	A	-5,241	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISC INCOME	B	-8,804	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	HHA OFFICE MISC INCOME	B	-1,440	HOME HEALTH AGENCY	101.00	0	33.10
33.11	340B OFFSET	A	-130,019	DRUGS CHARGED TO PATIENTS	73.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		581,204				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2024 2:41 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	1,320,297	229,792	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	2,401,663	1,381,258	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE	434,896	0	3.00
3.01	9.00	HOUSEKEEPING	HOUSEKEEPING	184,957	0	3.01
3.02	10.00	DIETARY	DIETARY	106,019	-31	3.02
3.03	13.00	NURSING ADMINISTRATION	NURSING ADMIN	54,291	0	3.03
3.04	14.00	CENTRAL SERVICE & SUPPLY	CENTRAL SUPPLY	0	31,553	3.04
3.05	15.00	PHARMACY	PHARMACY	295,548	61,705	3.05
4.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	7,304	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	238,693	0	4.01
4.02	30.00	ADULTS & PEDIATRICS	A&P	0	57,452	4.02
4.03	60.00	LABORATORY	LAB	0	20,826	4.03
4.04	88.00	RURAL HEALTH CLINIC	FORT BRANCH	0	26,426	4.04
4.05	88.01	RURAL HEALTH CLINIC II	MAIN STREET	0	44,629	4.05
4.06	90.03	PAIN MANAGEMENT	PAIN MGMT	0	126,139	4.06
4.07	194.00	MOB	FAMILY MEDICAL CLINIC	0	60,960	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1,395,045	1,046,754	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	217,308	0	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,656,021	3,087,463	5.00

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

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

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

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

6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00	G		0.00	HRS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/27/2024 2:41 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,090,505	0		1.00
2.00	1,020,405	0		2.00
3.00	434,896	0		3.00
3.01	184,957	0		3.01
3.02	106,050	0		3.02
3.03	54,291	0		3.03
3.04	-31,553	0		3.04
3.05	233,843	0		3.05
4.00	7,304	0		4.00
4.01	238,693	0		4.01
4.02	-57,452	0		4.02
4.03	-20,826	0		4.03
4.04	-26,426	0		4.04
4.05	-44,629	0		4.05
4.06	-126,139	0		4.06
4.07	-60,960	0		4.07
4.08	348,291	0		4.08
4.09	217,308	0		4.09
5.00	3,568,558			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	PFS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2024 2:41 pm

	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	5.00	ADMINISTRATIVE & GENERAL	10,585	10,585	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	369,980	0	369,980	0	0	2.00
3.00	50.00	OPERATING ROOM	626,715	626,715	0	0	0	3.00
4.00	60.00	LABORATORY	90,086	0	90,086	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	322,246	322,246	0	0	0	5.00
6.00	90.03	PAIN MANAGEMENT	8,099	8,099	0	0	0	6.00
7.00	91.00	EMERGENCY	1,093,085	0	1,093,085	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			2,520,796	967,645	1,553,151		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.03	PAIN MANAGEMENT	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	10,585		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	626,715		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	322,246		5.00
6.00	90.03	PAIN MANAGEMENT	0	0	0	8,099		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	967,645		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2024 2:41 pm

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		3.25	7.00
8.00	Optional travel expense rate per mile		0.63	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	10,791.81	13,808.06	9,175.28	0.00	9.00
10.00	AHSEA (see instructions)	97.62	97.62	73.22	36.61	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	48.81	48.81	36.61			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		1,053,496	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		1,011,026	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		2,064,522	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		335,907	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		2,400,429	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		2,400,429	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		17,816	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		17,816	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		19,002	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		19,002	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2024 2:41 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	97.62	73.22	36.61	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	2,400,429		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	19,002		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	2,419,431		63.00
64.00	Total cost of outside supplier services (from your records)	2,022,510		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	17,816		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	19,002		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,186		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,011,349	2,011,349				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,810,387	14,703	2,825,090			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,700,151	131,626	203,641	8,035,418	8,035,418	5.00
7.00	00700	OPERATION OF PLANT	1,967,991	569,229	43,131	2,580,351	588,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,557	37,043	14,026	134,626	30,679	8.00
9.00	00900	HOUSEKEEPING	596,799	20,908	64,107	681,814	155,372	9.00
10.00	01000	DIETARY	282,878	25,544	21,988	330,410	75,294	10.00
11.00	01100	CAFETERIA	352,941	69,563	60,767	483,271	110,128	11.00
13.00	01300	NURSING ADMINISTRATION	199,676	6,272	25,160	231,108	52,665	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	37,118	81,562	34,432	153,112	34,891	14.00
15.00	01500	PHARMACY	3,843,709	30,498	46,356	3,920,563	893,418	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,555	30,293	19,015	177,863	40,531	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,381,059	256,822	447,810	4,085,691	931,043	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,007,721	115,991	279,522	2,403,234	547,649	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,869,804	79,449	243,598	2,192,851	499,707	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	167,235	9,545	0	176,780	40,285	54.03
60.00	06000	LABORATORY	2,924,950	34,770	203,620	3,163,340	720,862	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,708	0	0	48,708	11,100	62.00
65.00	06500	RESPIRATORY THERAPY	770,416	36,634	110,923	917,973	209,188	65.00
66.00	06600	PHYSICAL THERAPY	2,092,172	91,584	0	2,183,756	497,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,900	0	0	243,900	55,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	267,636	0	0	267,636	60,989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-526	0	0	-526	0	73.00
76.00	03480	INFUSION THERAPY	240,190	24,248	32,859	297,297	67,748	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	590,581	0	62,706	653,287	148,871	88.00
88.01	08801	RURAL HEALTH CLINIC II	834,398	32,725	120,851	987,974	225,140	88.01
90.00	09000	CLINIC	282,122	0	22,330	304,452	69,379	90.00
90.01	09001	DIABETES	35	0	0	35	8	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	160,294	35,793	30,207	226,294	51,568	90.03
91.00	09100	EMERGENCY	3,558,008	176,850	294,820	4,029,678	918,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	918,918	11,476	114,992	1,045,386	238,223	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,372,732	1,923,128	2,496,861	39,956,282	7,274,245	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	2,923,775	58,473	328,229	3,310,477	754,391	194.00
194.01	07951	FOUNDATION	12	29,748	0	29,760	6,782	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,296,519	2,011,349	2,825,090	43,296,519	8,035,418	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,168,361					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,574	255,879				8.00
9.00	00900	HOUSEKEEPING	51,121	0	888,307			9.00
10.00	01000	DIETARY	62,457	0	18,331	486,492		10.00
11.00	01100	CAFETERIA	170,090	0	49,920	0	813,409	11.00
13.00	01300	NURSING ADMINISTRATION	15,336	0	4,501	0	9,161	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	199,429	0	58,531	0	12,538	14.00
15.00	01500	PHARMACY	74,571	0	21,886	0	16,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,070	0	21,739	0	6,924	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	627,960	255,879	184,302	486,492	163,048	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	283,613	0	83,239	0	101,793	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,261	0	57,014	0	88,700	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	23,338	0	6,850	0	0	54.03
60.00	06000	LABORATORY	85,017	0	24,952	0	74,143	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	89,574	0	26,289	0	40,390	65.00
66.00	06600	PHYSICAL THERAPY	223,934	0	65,723	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	59,290	0	17,401	0	11,965	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	80,016	0	23,484	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	8,425	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	87,518	0	25,686	0	10,705	90.03
91.00	09100	EMERGENCY	432,421	0	126,913	0	107,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	28,061	0	8,236	0	41,871	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,952,651	255,879	824,997	486,492	693,893	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	142,973	0	41,962	0	119,516	194.00
194.01	07951	FOUNDATION	72,737	0	21,348	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,168,361	255,879	888,307	486,492	813,409	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	312,771					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	458,501				14.00
15.00	01500	PHARMACY	9,912	16,807	4,954,036			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	321,127		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	127,821	30,647	0	11,930	6,904,813	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,274	111,476	0	38,028	3,623,306	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,777	0	90,801	3,135,111	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	116	0	2,612	249,981	54.03
60.00	06000	LABORATORY	0	105,872	0	37,241	4,211,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	834	0	540	61,182	62.00
65.00	06500	RESPIRATORY THERAPY	31,394	5,355	0	18,911	1,339,074	65.00
66.00	06600	PHYSICAL THERAPY	0	2,305	0	30,860	3,004,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,647	0	0	337,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,960	0	0	369,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,954,036	50,747	5,004,257	73.00
76.00	03480	INFUSION THERAPY	8,804	3,729	0	2,300	468,534	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,735	0	0	803,893	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	7,953	0	0	1,324,567	88.01
90.00	09000	CLINIC	0	21,050	0	2,243	405,549	90.00
90.01	09001	DIABETES	0	2	0	30	75	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	80,566	24	0	1,761	484,122	90.03
91.00	09100	EMERGENCY	0	55,221	0	33,123	5,702,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,606	0	0	1,364,383	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	312,771	456,116	4,954,036	321,127	38,794,188	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	2,385	0	0	4,371,704	194.00
194.01	07951	FOUNDATION	0	0	0	0	130,627	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	312,771	458,501	4,954,036	321,127	43,296,519	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,904,813		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,623,306		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,135,111		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	249,981		54.03
60.00	06000	LABORATORY	0	4,211,427		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	61,182		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,339,074		65.00
66.00	06600	PHYSICAL THERAPY	0	3,004,212		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	337,127		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	369,585		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,004,257		73.00
76.00	03480	INFUSION THERAPY	0	468,534		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	803,893		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,324,567		88.01
90.00	09000	CLINIC	0	405,549		90.00
90.01	09001	DIABETES	0	75		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	484,122		90.03
91.00	09100	EMERGENCY	0	5,702,990		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,364,383		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	38,794,188		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,371,704		194.00
194.01	07951	FOUNDATION	0	130,627		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	43,296,519		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,703	14,703	14,703		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	131,626	131,626	1,060	132,686	5.00
7.00	00700	OPERATION OF PLANT	0	569,229	569,229	224	9,710	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,043	37,043	73	507	8.00
9.00	00900	HOUSEKEEPING	0	20,908	20,908	334	2,566	9.00
10.00	01000	DIETARY	0	25,544	25,544	114	1,243	10.00
11.00	01100	CAFETERIA	0	69,563	69,563	316	1,819	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,272	6,272	131	870	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	81,562	81,562	179	576	14.00
15.00	01500	PHARMACY	0	30,498	30,498	241	14,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,293	30,293	99	669	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	256,822	256,822	2,333	15,370	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	115,991	115,991	1,455	9,043	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,449	79,449	1,268	8,252	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	9,545	9,545	0	665	54.03
60.00	06000	LABORATORY	0	34,770	34,770	1,060	11,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	183	62.00
65.00	06500	RESPIRATORY THERAPY	0	36,634	36,634	577	3,454	65.00
66.00	06600	PHYSICAL THERAPY	0	91,584	91,584	0	8,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,007	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	24,248	24,248	171	1,119	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	326	2,458	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	32,725	32,725	629	3,718	88.01
90.00	09000	CLINIC	0	0	0	116	1,146	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	35,793	35,793	157	852	90.03
91.00	09100	EMERGENCY	0	176,850	176,850	1,534	15,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	11,476	11,476	598	3,934	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,923,128	1,923,128	12,995	120,117	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	58,473	58,473	1,708	12,457	194.00
194.01	07951	FOUNDATION	0	29,748	29,748	0	112	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,011,349	2,011,349	14,703	132,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	579,163					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,557	54,180				8.00
9.00	00900	HOUSEKEEPING	9,345	0	33,153			9.00
10.00	01000	DIETARY	11,417	0	684	39,002		10.00
11.00	01100	CAFETERIA	31,092	0	1,863	0	104,653	11.00
13.00	01300	NURSING ADMINISTRATION	2,803	0	168	0	1,179	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	36,455	0	2,184	0	1,613	14.00
15.00	01500	PHARMACY	13,631	0	817	0	2,172	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,540	0	811	0	891	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,787	54,180	6,879	39,002	20,977	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,843	0	3,107	0	13,097	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,510	0	2,128	0	11,412	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	4,266	0	256	0	0	54.03
60.00	06000	LABORATORY	15,541	0	931	0	9,539	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	16,374	0	981	0	5,197	65.00
66.00	06600	PHYSICAL THERAPY	40,934	0	2,453	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	10,838	0	649	0	1,539	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,627	0	876	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	1,084	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	15,998	0	959	0	1,377	90.03
91.00	09100	EMERGENCY	79,045	0	4,737	0	13,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,129	0	307	0	5,387	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,732	54,180	30,790	39,002	89,276	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	26,135	0	1,566	0	15,377	194.00
194.01	07951	FOUNDATION	13,296	0	797	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	579,163	54,180	33,153	39,002	104,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,423					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	122,569				14.00
15.00	01500	PHARMACY	362	4,493	66,967			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	46,303		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,670	8,193	0	1,718	524,931	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,982	29,799	0	5,478	231,795	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,148	0	13,127	154,294	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	31	0	376	15,139	54.03
60.00	06000	LABORATORY	0	28,302	0	5,364	107,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	223	0	78	484	62.00
65.00	06500	RESPIRATORY THERAPY	1,146	1,432	0	2,724	68,519	65.00
66.00	06600	PHYSICAL THERAPY	0	616	0	4,445	148,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,064	0	0	10,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,950	0	0	11,957	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	66,967	7,310	74,277	73.00
76.00	03480	INFUSION THERAPY	321	997	0	331	40,213	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	464	0	0	3,248	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,126	0	0	54,701	88.01
90.00	09000	CLINIC	0	5,627	0	323	8,296	90.00
90.01	09001	DIABETES	0	1	0	4	5	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2,942	7	0	254	58,339	90.03
91.00	09100	EMERGENCY	0	14,762	0	4,771	310,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	697	0	0	27,528	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,423	121,932	66,967	46,303	1,851,043	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	637	0	0	116,353	194.00
194.01	07951	FOUNDATION	0	0	0	0	43,953	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,423	122,569	66,967	46,303	2,011,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	524,931		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	231,795		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,294		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	15,139		54.03
60.00	06000	LABORATORY	0	107,411		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	484		62.00
65.00	06500	RESPIRATORY THERAPY	0	68,519		65.00
66.00	06600	PHYSICAL THERAPY	0	148,249		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,982		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,957		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,277		73.00
76.00	03480	INFUSION THERAPY	0	40,213		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,248		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	54,701		88.01
90.00	09000	CLINIC	0	8,296		90.00
90.01	09001	DIABETES	0	5		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	58,339		90.03
91.00	09100	EMERGENCY	0	310,675		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	27,528		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,851,043		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	116,353		194.00
194.01	07951	FOUNDATION	0	43,953		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,011,349		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	88,506					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	647	14,027,925				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,792	1,011,175	-8,035,418	35,261,627		5.00
7.00	00700	OPERATION OF PLANT	25,048	214,165	0	2,580,351	57,019	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	69,645	0	134,626	1,630	8.00
9.00	00900	HOUSEKEEPING	920	318,324	0	681,814	920	9.00
10.00	01000	DIETARY	1,124	109,180	0	330,410	1,124	10.00
11.00	01100	CAFETERIA	3,061	301,740	0	483,271	3,061	11.00
13.00	01300	NURSING ADMINISTRATION	276	124,932	0	231,108	276	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,589	170,972	0	153,112	3,589	14.00
15.00	01500	PHARMACY	1,342	230,179	0	3,920,563	1,342	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	94,418	0	177,863	1,333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,301	2,223,566	0	4,085,691	11,301	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	1,387,965	0	2,403,234	5,104	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	1,209,585	0	2,192,851	3,496	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	0	176,780	420	54.03
60.00	06000	LABORATORY	1,530	1,011,071	0	3,163,340	1,530	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	48,708	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	550,786	0	917,973	1,612	65.00
66.00	06600	PHYSICAL THERAPY	4,030	0	0	2,183,756	4,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	243,900	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	267,636	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	526	0	0	73.00
76.00	03480	INFUSION THERAPY	1,067	163,159	0	297,297	1,067	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	311,366	0	653,287	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,440	600,086	0	987,974	1,440	88.01
90.00	09000	CLINIC	0	110,880	0	304,452	0	90.00
90.01	09001	DIABETES	0	0	0	35	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	149,994	0	226,294	1,575	90.03
91.00	09100	EMERGENCY	7,782	1,463,926	0	4,029,678	7,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	570,992	0	1,045,386	505	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,624	12,398,106	-8,034,892	31,921,390	53,137	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	2,573	1,629,819	0	3,310,477	2,573	194.00
194.01	07951	FOUNDATION	1,309	0	0	29,760	1,309	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,011,349	2,825,090		8,035,418	3,168,361	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.725567	0.201390		0.227880	55.566758	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		14,703		132,686	579,163	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001048		0.003763	10.157369	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,293					8.00
9.00	00900	HOUSEKEEPING	0	54,469				9.00
10.00	01000	DIETARY	0	1,124	1,293			10.00
11.00	01100	CAFETERIA	0	3,061	0	11,092,244		11.00
13.00	01300	NURSING ADMINISTRATION	0	276	0	124,932	5,651,485	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	3,589	0	170,972	0	14.00
15.00	01500	PHARMACY	0	1,342	0	230,179	179,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,333	0	94,418	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,293	11,301	1,293	2,223,401	2,309,593	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,104	0	1,388,130	980,686	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,496	0	1,209,585	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	420	0	0	0	54.03
60.00	06000	LABORATORY	0	1,530	0	1,011,071	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,612	0	550,786	567,262	65.00
66.00	06600	PHYSICAL THERAPY	0	4,030	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	1,067	0	163,159	159,076	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,440	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	114,888	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	1,575	0	145,986	1,455,760	90.03
91.00	09100	EMERGENCY	0	7,782	0	1,463,926	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	505	0	570,992	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,293	50,587	1,293	9,462,425	5,651,485	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	2,573	0	1,629,819	0	194.00
194.01	07951	FOUNDATION	0	1,309	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	255,879	888,307	486,492	813,409	312,771	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	197.895592	16.308487	376.250580	0.073331	0.055343	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,180	33,153	39,002	104,653	11,423	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	41.902552	0.608658	30.163960	0.009435	0.002021	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 2:41 pm

		Cost Center Description	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,995,900				14.00
15.00	01500	PHARMACY	109,822	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2	0	92,337,829		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	200,250	0	3,430,111		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	728,392	0	10,933,732		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,953	0	26,114,552		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	760	0	750,877		54.03
60.00	06000	LABORATORY	691,779	0	10,707,470		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,449	0	155,150		62.00
65.00	06500	RESPIRATORY THERAPY	34,991	0	5,437,290		65.00
66.00	06600	PHYSICAL THERAPY	15,060	0	8,872,801		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245,991	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	267,636	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	14,590,837		73.00
76.00	03480	INFUSION THERAPY	24,366	0	661,322		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	11,335	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	51,969	0	0		88.01
90.00	09000	CLINIC	137,544	0	644,932		90.00
90.01	09001	DIABETES	13	0	8,751		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	159	0	506,380		90.03
91.00	09100	EMERGENCY	360,817	0	9,523,624		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	17,030	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,980,318	100	92,337,829		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	15,582	0	0		194.00
194.01	07951	FOUNDATION	0	0	0		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	458,501	4,954,036	321,127		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.153043	49,540.360000	0.003478		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,569	66,967	46,303		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040912	669.670000	0.000501		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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	6,904,813		6,904,813	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,623,306		3,623,306	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,135,111		3,135,111	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	249,981		249,981	0	0	54.03
60.00	06000	LABORATORY	4,211,427		4,211,427	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	61,182		61,182	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,339,074	0	1,339,074	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,004,212	0	3,004,212	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	337,127		337,127	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,585		369,585	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,004,257		5,004,257	0	0	73.00
76.00	03480	INFUSION THERAPY	468,534		468,534	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	803,893		803,893	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,324,567		1,324,567	0	0	88.01
90.00	09000	CLINIC	405,549		405,549	0	0	90.00
90.01	09001	DIABETES	75		75	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	484,122		484,122	0	0	90.03
91.00	09100	EMERGENCY	5,702,990		5,702,990	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,868,548		2,868,548		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,364,383		1,364,383		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,662,736	0	41,662,736	0	0	200.00
201.00		Less Observation Beds	2,868,548		2,868,548		0	201.00
202.00		Total (see instructions)	38,794,188	0	38,794,188	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	2,108,899		2,108,899			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,024	8,484,515	8,556,539	0.423455	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	268,468	24,924,087	25,192,555	0.124446	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	750,750	750,750	0.332975	0.000000	54.03
60.00	06000	LABORATORY	665,153	10,037,670	10,702,823	0.393487	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20,628	191,894	212,522	0.287885	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	277,679	4,276,627	4,554,306	0.294024	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,244,329	7,708,396	8,952,725	0.335564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,934	631,034	860,968	0.391567	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	392	936,335	936,727	0.394549	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,348,676	14,199,192	15,547,868	0.321861	0.000000	73.00
76.00	03480	INFUSION THERAPY	4,385	682,381	686,766	0.682232	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	543,395	543,395			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,855,229	1,855,229			88.01
90.00	09000	CLINIC	609	385,395	386,004	1.050634	0.000000	90.00
90.01	09001	DIABETES	0	8,751	8,751	0.008570	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	198,761	198,761	2.435699	0.000000	90.03
91.00	09100	EMERGENCY	137,306	9,238,937	9,376,243	0.608238	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,222	1,207,607	1,248,829	2.296990	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	989,092	989,092			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,419,704	87,250,048	93,669,752			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,419,704	87,250,048	93,669,752			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	6,904,813		6,904,813	0	6,904,813	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,623,306		3,623,306	0	3,623,306	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,135,111		3,135,111	0	3,135,111	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	249,981		249,981	0	249,981	54.03
60.00	06000	LABORATORY	4,211,427		4,211,427	0	4,211,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	61,182		61,182	0	61,182	62.00
65.00	06500	RESPIRATORY THERAPY	1,339,074	0	1,339,074	0	1,339,074	65.00
66.00	06600	PHYSICAL THERAPY	3,004,212	0	3,004,212	0	3,004,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	337,127		337,127	0	337,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,585		369,585	0	369,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,004,257		5,004,257	0	5,004,257	73.00
76.00	03480	INFUSION THERAPY	468,534		468,534	0	468,534	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	803,893		803,893	0	803,893	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,324,567		1,324,567	0	1,324,567	88.01
90.00	09000	CLINIC	405,549		405,549	0	405,549	90.00
90.01	09001	DIABETES	75		75	0	75	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	484,122		484,122	0	484,122	90.03
91.00	09100	EMERGENCY	5,702,990		5,702,990	0	5,702,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,868,548		2,868,548		2,868,548	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,364,383		1,364,383		1,364,383	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,662,736	0	41,662,736	0	41,662,736	200.00
201.00		Less Observation Beds	2,868,548		2,868,548		2,868,548	201.00
202.00		Total (see instructions)	38,794,188	0	38,794,188	0	38,794,188	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	2,108,899		2,108,899			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,024	8,484,515	8,556,539	0.423455	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	268,468	24,924,087	25,192,555	0.124446	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	750,750	750,750	0.332975	0.000000	54.03
60.00	06000	LABORATORY	665,153	10,037,670	10,702,823	0.393487	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20,628	191,894	212,522	0.287885	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	277,679	4,276,627	4,554,306	0.294024	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,244,329	7,708,396	8,952,725	0.335564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,934	631,034	860,968	0.391567	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	392	936,335	936,727	0.394549	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,348,676	14,199,192	15,547,868	0.321861	0.000000	73.00
76.00	03480	INFUSION THERAPY	4,385	682,381	686,766	0.682232	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	543,395	543,395	1.479390	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,855,229	1,855,229	0.713964	0.000000	88.01
90.00	09000	CLINIC	609	385,395	386,004	1.050634	0.000000	90.00
90.01	09001	DIABETES	0	8,751	8,751	0.008570	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	198,761	198,761	2.435699	0.000000	90.03
91.00	09100	EMERGENCY	137,306	9,238,937	9,376,243	0.608238	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,222	1,207,607	1,248,829	2.296990	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	989,092	989,092			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,419,704	87,250,048	93,669,752			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,419,704	87,250,048	93,669,752			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 2:41 pm

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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 2:41 pm

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	231,795	8,556,539	0.027090	51,583	1,397	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,294	25,192,555	0.006125	39,367	241	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	15,139	750,750	0.020165	0	0	54.03
60.00	06000	LABORATORY	107,411	10,702,823	0.010036	113,425	1,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	484	212,522	0.002277	6,546	15	62.00
65.00	06500	RESPIRATORY THERAPY	68,519	4,554,306	0.015045	56,897	856	65.00
66.00	06600	PHYSICAL THERAPY	148,249	8,952,725	0.016559	29,722	492	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,982	860,968	0.012755	46,810	597	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,957	936,727	0.012765	392	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,277	15,547,868	0.004777	176,666	844	73.00
76.00	03480	INFUSION THERAPY	40,213	686,766	0.058554	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,248	543,395	0.005977	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	54,701	1,855,229	0.029485	0	0	88.01
90.00	09000	CLINIC	8,296	386,004	0.021492	0	0	90.00
90.01	09001	DIABETES	5	8,751	0.000571	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	58,339	198,761	0.293513	0	0	90.03
91.00	09100	EMERGENCY	310,675	9,376,243	0.033134	1,651	55	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	218,078	1,248,829	0.174626	0	0	92.00
200.00		Total (lines 50 through 199)	1,516,662	90,571,761		523,059	5,640	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 2:41 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 2:41 pm

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	8,556,539	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,192,555	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	750,750	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	10,702,823	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	212,522	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,554,306	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,952,725	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	860,968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	936,727	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,547,868	0.000000	73.00
76.00	03480	INFUSION THERAPY	0	0	0	686,766	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	543,395	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,855,229	0.000000	88.01
90.00	09000	CLINIC	0	0	0	386,004	0.000000	90.00
90.01	09001	DIABETES	0	0	0	8,751	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	198,761	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	9,376,243	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,248,829	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,571,761		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 2:41 pm

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	51,583	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	39,367	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	0	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	113,425	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	6,546	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	56,897	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	29,722	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	46,810	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	392	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	176,666	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	1,651	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		523,059	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 2:41 pm

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	0.423455	0	1,659,469	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124446	0	5,496,396	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.332975	0	231,762	0	0	54.03
60.00	06000	LABORATORY	0.393487	0	2,448,485	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287885	0	32,996	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.294024	0	1,288,468	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335564	0	2,089,550	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.391567	0	132,227	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394549	0	202,840	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321861	0	6,790,533	900	0	73.00
76.00	03480	INFUSION THERAPY	0.682232	0	251,166	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.050634	0	136,991	0	0	90.00
90.01	09001	DIABETES	0.008570	0	4,347	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.435699	0	66,954	0	0	90.03
91.00	09100	EMERGENCY	0.608238	0	1,498,689	128	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.296990	0	383,314	0	0	92.00
200.00		Subtotal (see instructions)		0	22,714,187	1,028	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	22,714,187	1,028	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 2:41 pm

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	702,710	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,004	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	77,171	0		54.03
60.00	06000	LABORATORY	963,447	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,499	0		62.00
65.00	06500	RESPIRATORY THERAPY	378,841	0		65.00
66.00	06600	PHYSICAL THERAPY	701,178	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,776	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,030	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,185,608	290		73.00
76.00	03480	INFUSION THERAPY	171,353	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	143,927	0		90.00
90.01	09001	DIABETES	37	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	163,080	0		90.03
91.00	09100	EMERGENCY	911,560	78		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	880,468	0		92.00
200.00		Subtotal (see instructions)	8,104,689	368		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,104,689	368		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 2:41 pm

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)	3,322	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,510	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)	477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	235	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)	654	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	177	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)	746	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	201	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)	235	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)	654	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,904,813	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)	44,328	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)	198,675	25.00
26.00	Total swing-bed cost (see instructions)	2,711,676	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,193,137	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)	4,193,137	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)	2,776.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	558,159	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)	558,159	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 2:41 pm

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)						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)	176,310	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)	734,469	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)	652,574	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,816,099	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,468,673	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,033	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,776.91	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 2:41 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,868,548	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	524,931	6,904,813	0.076024	2,868,548	218,078	90.00
91.00	Nursing Program cost	0	6,904,813	0.000000	2,868,548	0	91.00
92.00	Allied health cost	0	6,904,813	0.000000	2,868,548	0	92.00
93.00	All other Medical Education	0	6,904,813	0.000000	2,868,548	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 2:41 pm

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)	3,322	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,510	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)	477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	889	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	889	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)	34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,904,813	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,558,720	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,346,093	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)	4,346,093	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)	2,878.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,269	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)	17,269	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 2:41 pm

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)						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)	1,757	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)	19,026	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,033	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,878.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 2:41 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,973,191	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	524,931	6,904,813	0.076024	2,973,191	226,034	90.00
91.00	Nursing Program cost	0	6,904,813	0.000000	2,973,191	0	91.00
92.00	Allied health cost	0	6,904,813	0.000000	2,973,191	0	92.00
93.00	All other Medical Education	0	6,904,813	0.000000	2,973,191	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 2:41 pm

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		199,288		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.423455	51,583	21,843	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124446	39,367	4,899	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.332975	0	0	54.03
60.00	06000	LABORATORY	0.393487	113,425	44,631	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287885	6,546	1,884	62.00
65.00	06500	RESPIRATORY THERAPY	0.294024	56,897	16,729	65.00
66.00	06600	PHYSICAL THERAPY	0.335564	29,722	9,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.391567	46,810	18,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394549	392	155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321861	176,666	56,862	73.00
76.00	03480	INFUSION THERAPY	0.682232	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	1.050634	0	0	90.00
90.01	09001	DIABETES	0.008570	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.435699	0	0	90.03
91.00	09100	EMERGENCY	0.608238	1,651	1,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.296990	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		523,059	176,310	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)		523,059		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 2:41 pm

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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.423455	2,243	950	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124446	13,385	1,666	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.332975	0	0	54.03
60.00	06000	LABORATORY	0.393487	84,806	33,370	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287885	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.294024	45,553	13,394	65.00
66.00	06600	PHYSICAL THERAPY	0.335564	556,494	186,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.391567	53,440	20,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321861	461,431	148,517	73.00
76.00	03480	INFUSION THERAPY	0.682232	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	1.050634	519	545	90.00
90.01	09001	DIABETES	0.008570	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.435699	0	0	90.03
91.00	09100	EMERGENCY	0.608238	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.296990	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,217,871	406,106	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,217,871		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 2:41 pm

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		1,669		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.423455	647	274	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124446	800	100	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.332975	0	0	54.03
60.00	06000	LABORATORY	0.393487	1,789	704	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.287885	34	10	62.00
65.00	06500	RESPIRATORY THERAPY	0.294024	796	234	65.00
66.00	06600	PHYSICAL THERAPY	0.335564	53	18	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.391567	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321861	0	0	73.00
76.00	03480	INFUSION THERAPY	0.682232	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.479390	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.713964	0	0	88.01
90.00	09000	CLINIC	1.050634	0	0	90.00
90.01	09001	DIABETES	0.008570	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.435699	0	0	90.03
91.00	09100	EMERGENCY	0.608238	685	417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.296990	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,804	1,757	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,804		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/27/2024 2:41 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,105,057	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,105,057	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	8,186,108	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)	69,447	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,025,176	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)	4,091,485	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,091,485	30.00
31.00	Primary payer payments	5,937	31.00
32.00	Subtotal (line 30 minus line 31)	4,085,548	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)	256,799	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	166,919	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	238,229	36.00
37.00	Subtotal (see instructions)	4,252,467	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,252,467	40.00
40.01	Sequestration adjustment (see instructions)	85,049	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,819,748	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)	-652,330	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 2:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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		608,918		4,819,748	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	05/18/2023	87,700		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)		87,700		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)		696,618		4,819,748	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		32,153		652,330	6.02
7.00	Total Medicare program liability (see instructions)		664,465		4,167,418	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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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		2,500,558		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	05/18/2023	221,400		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)		221,400		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)		2,721,958		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		104,360		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,826,318		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: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/27/2024 2:41 pm
	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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/27/2024 2:41 pm

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)	2,493,360	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)	410,167	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	889	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)	2,903,527	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,903,527	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)	2,903,527	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,529	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,883,998	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)	2,883,998	0	19.00
19.01	Sequestration adjustment (see instructions)	57,680	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	2,721,958	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)	104,360	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: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/27/2024 2:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	734,469	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)	734,469	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	741,814	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)	741,814	19.00
20.00	Deductibles (exclude professional component)	72,896	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	668,918	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	668,918	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,012	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,108	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,528	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	678,026	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)	678,026	30.00
30.01	Sequestration adjustment (see instructions)	13,561	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	696,618	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)	-32,153	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: 15-1319	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 2:41 pm
	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	19,026		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)	19,026	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)	19,026	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,669		8.00
9.00	Ancillary service charges	4,804	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)	6,473	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)	6,473	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	12,553	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)	19,026	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)	19,026	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	12,553	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	19,026	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)	19,026	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	19,026	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)	19,026	0	40.00
41.00	Interim payments	1,634	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	17,392	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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/27/2024 2:41 pm

		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	35,629,758	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	6,531,952	0	0	0	4.00
5.00	Other receivable	903,207	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,114,253	0	0	0	6.00
7.00	Inventory	398,563	0	0	0	7.00
8.00	Prepaid expenses	601,953	0	0	0	8.00
9.00	Other current assets	601,406	0	0	0	9.00
10.00	Due from other funds	-355,035	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,197,551	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	8,035,666	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,702,160	0	0	0	15.00
16.00	Accumulated depreciation	-1,647,191	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	9,893,380	0	0	0	19.00
20.00	Accumulated depreciation	-4,478,419	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	13,926,840	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,708,574	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,708,574	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,832,965	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,839,310	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,400,675	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-1,485,074	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	3,180,631	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,935,542	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,909,332	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)	9,909,332	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,844,874	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	40,988,091				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)	40,988,091	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,832,965	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/27/2024 2:41 pm

		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		30,139,056		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,849,035				2.00
3.00	Total (sum of line 1 and line 2)		40,988,091		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)		40,988,091		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)		40,988,091		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: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/27/2024 2:41 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,430,111		3,430,111	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	763,580		763,580	5.00
6.00	Swing bed - NF	792,783		792,783	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)	4,986,474		4,986,474	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)	4,986,474		4,986,474	17.00
18.00	Ancillary services	1,287,058	74,216,705	75,503,763	18.00
19.00	Outpatient services	145,325	10,023,231	10,168,556	19.00
20.00	RURAL HEALTH CLINIC	0	543,395	543,395	20.00
20.01	RURAL HEALTH CLINIC II	0	1,855,229	1,855,229	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		989,092	989,092	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	1,679,036	1,679,036	27.00
27.01	PROFESSIONAL	471,697	6,973,232	7,444,929	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,890,554	96,279,920	103,170,474	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,715,315		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,715,315		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/27/2024 2:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	103,170,474	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,444,018	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,726,456	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,715,315	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,011,141	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	55,180	6.00
7.00	Income from investments	1,392,986	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	145,420	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	130,631	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	58,321	24.00
24.50	COVID-19 PHE Funding	1,055,356	24.50
25.00	Total other income (sum of lines 6-24)	2,837,894	25.00
26.00	Total (line 5 plus line 25)	10,849,035	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)	10,849,035	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H Date/Time Prepared: 2/27/2024 2:41 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	104,369	10,875	0	0	93,336	208,580	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	197,639	20,593	0	0	222,052	440,284	6.00
7.00	Physical Therapy	149,706	15,599	0	0	0	165,305	7.00
8.00	Occupational Therapy	96,530	10,058	0	0	0	106,588	8.00
9.00	Speech Pathology	7,016	731	0	0	0	7,747	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	15,732	1,639	0	0	0	17,371	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	20,656	20,656	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	570,992	59,495	0	0	336,044	966,531	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-42,550	166,030	-1,440	164,590			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	440,284	0	440,284			6.00
7.00	Physical Therapy	0	165,305	0	165,305			7.00
8.00	Occupational Therapy	0	106,588	0	106,588			8.00
9.00	Speech Pathology	0	7,747	0	7,747			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	17,371	0	17,371			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	-3,623	17,033	0	17,033			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-46,173	920,358	-1,440	918,918			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-1 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	164,590	0	0	0	0	164,590	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	440,284	0	0	0	0	440,284	6.00
7.00	Physical Therapy	165,305	0	0	0	0	165,305	7.00
8.00	Occupational Therapy	106,588	0	0	0	0	106,588	8.00
9.00	Speech Pathology	7,747	0	0	0	0	7,747	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	17,371	0	0	0	0	17,371	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	17,033	0	0	0		17,033	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	918,918	0	0	0	0	918,918	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	164,590						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	96,068	536,352					6.00
7.00	Physical Therapy	36,069	201,374					7.00
8.00	Occupational Therapy	23,257	129,845					8.00
9.00	Speech Pathology	1,690	9,437					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	3,790	21,161					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	3,716	20,749					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		918,918					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-1 Part II Date/Time Prepared: 2/27/2024 2:41 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-164,590	754,328	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	440,284	6.00
7.00	Physical Therapy	0	0	0	0	0	165,305	7.00
8.00	Occupational Therapy	0	0	0	0	0	106,588	8.00
9.00	Speech Pathology	0	0	0	0	0	7,747	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	17,371	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	17,033	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-164,590	754,328	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		164,590	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.218194	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445

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

Worksheet H-2 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	11,476	114,992	126,468	28,820	28,061	1.00
2.00	Skilled Nursing Care	536,352	0	0	536,352	122,224	0	2.00
3.00	Physical Therapy	201,374	0	0	201,374	45,889	0	3.00
4.00	Occupational Therapy	129,845	0	0	129,845	29,589	0	4.00
5.00	Speech Pathology	9,437	0	0	9,437	2,151	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	21,161	0	0	21,161	4,822	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	20,749	0	0	20,749	4,728	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	918,918	11,476	114,992	1,045,386	238,223	28,061	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	8,236	0	41,871	0	2,606	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	8,236	0	41,871	0	2,606	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	236,062	0	236,062		1.00
2.00	Skilled Nursing Care	0	0	658,576	0	658,576	137,785	2.00
3.00	Physical Therapy	0	0	247,263	0	247,263	51,731	3.00
4.00	Occupational Therapy	0	0	159,434	0	159,434	33,356	4.00
5.00	Speech Pathology	0	0	11,588	0	11,588	2,424	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	25,983	0	25,983	5,436	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	25,477	0	25,477	5,330	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,364,383	0	1,364,383	236,062	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.209215	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	796,361	2.00
3.00	Physical Therapy	298,994	3.00
4.00	Occupational Therapy	192,790	4.00
5.00	Speech Pathology	14,012	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	31,419	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	30,807	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,364,383	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part II | Date/Time Prepared: 2/27/2024 2:41 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	505	570,992	0	126,468	505	0	1.00
2.00	Skilled Nursing Care	0	0	0	536,352	0	0	2.00
3.00	Physical Therapy	0	0	0	201,374	0	0	3.00
4.00	Occupational Therapy	0	0	0	129,845	0	0	4.00
5.00	Speech Pathology	0	0	0	9,437	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	21,161	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	20,749	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	570,992		1,045,386	505	0	20.00
21.00	Total cost to be allocated	11,476	114,992		238,223	28,061	0	21.00
22.00	Unit cost multiplier	22.724752	0.201390		0.227880	55.566337	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	505	0	570,992	0	17,030	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	0	570,992	0	17,030	0	20.00
21.00	Total cost to be allocated	8,236	0	41,871	0	2,606	0	21.00
22.00	Unit cost multiplier	16.308911	0.000000	0.073330	0.000000	0.153024	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319 HHA CCN: 15-7445

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

Worksheet H-2 Part II Date/Time Prepared: 2/27/2024 2:41 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 2/27/2024 2:41 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	796,361		796,361	2,676	297.59	1.00
2.00	Physical Therapy	3.00	298,994	0	298,994	2,027	147.51	2.00
3.00	Occupational Therapy	4.00	192,790	0	192,790	1,307	147.51	3.00
4.00	Speech Pathology	5.00	14,012	0	14,012	95	147.49	4.00
5.00	Medical Social Services	6.00	0		0	1	0.00	5.00
6.00	Home Health Aide	7.00	31,419		31,419	115	273.21	6.00
7.00	Total (sum of lines 1-6)		1,333,576	0	1,333,576	6,221		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,692			8.00
9.00	Physical Therapy		99915	0	1,283			9.00
10.00	Occupational Therapy		99915	0	768			10.00
11.00	Speech Pathology		99915	0	67			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	70			13.00
14.00	Total (sum of lines 8-13)			0	3,880			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	30,807	0	30,807	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,692		0	503,522		1.00
2.00	Physical Therapy	0	1,283		0	189,255		2.00
3.00	Occupational Therapy	0	768		0	113,288		3.00
4.00	Speech Pathology	0	67		0	9,882		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	70		0	19,125		6.00
7.00	Total (sum of lines 1-6)	0	3,880		0	835,072		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2024 2:41 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	503,522						1.00
2.00	Physical Therapy	189,255						2.00
3.00	Occupational Therapy	113,288						3.00
4.00	Speech Pathology	9,882						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	19,125						6.00
7.00	Total (sum of lines 1-6)	835,072						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319
HHA CCN: 15-7445

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

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.335564	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.391567	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.321861	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319 HHA CCN: 15-7445	Period: From 10/01/2022 To 09/30/2023	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2024 2:41 pm
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		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	500,962	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	109,080	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,120	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,264	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	28,296	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	202	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	644,924	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	644,924	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	644,924	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	644,924	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	644,924	31.00
31.01	Sequestration adjustment (see instructions)	0	12,898	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	632,025	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-5 Date/Time Prepared: 2/27/2024 2:41 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		632,025	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		632,025	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		632,026	7.00

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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	90,264	90,264	2.00
3.00	Nurse Practitioner	199,438	0	199,438	-90,264	109,174	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	199,438	0	199,438	0	199,438	10.00
11.00	Physician Services Under Agreement	0	0	0	20,592	20,592	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	20,592	20,592	14.00
15.00	Medical Supplies	0	44,346	44,346	-28,729	15,617	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	44,346	44,346	-28,729	15,617	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	199,438	44,346	243,784	-8,137	235,647	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	74,448	74,448	-20,592	53,856	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	74,448	74,448	-20,592	53,856	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,425	9,425	0	9,425	29.00
30.00	Administrative Costs	111,928	212,098	324,026	-5,947	318,079	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	111,928	221,523	333,451	-5,947	327,504	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	311,366	340,317	651,683	-34,676	617,007	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	90,264		2.00
3.00	Nurse Practitioner	0	109,174		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	199,438		10.00
11.00	Physician Services Under Agreement	0	20,592		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	20,592		14.00
15.00	Medical Supplies	0	15,617		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,617		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	235,647		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	53,856		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	53,856		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,425		29.00
30.00	Administrative Costs	-26,426	291,653		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-26,426	301,078		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-26,426	590,581		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 2:41 pm

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	304,066	0	304,066	0	304,066	1.00
2.00	Physician Assistant	1,485	0	1,485	0	1,485	2.00
3.00	Nurse Practitioner	92,729	0	92,729	0	92,729	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	132,524	0	132,524	0	132,524	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	530,804	0	530,804	0	530,804	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	145,994	145,994	-90,546	55,448	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	145,994	145,994	-90,546	55,448	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	530,804	145,994	676,798	-90,546	586,252	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	7,549	7,549	-7,545	4	29.00
30.00	Administrative Costs	69,282	237,784	307,066	-14,295	292,771	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	69,282	245,333	314,615	-21,840	292,775	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	600,086	391,327	991,413	-112,386	879,027	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	304,066		1.00
2.00	Physician Assistant	0	1,485		2.00
3.00	Nurse Practitioner	0	92,729		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	132,524		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	530,804		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	55,448		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	55,448		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	586,252		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	4		29.00
30.00	Administrative Costs	-44,629	248,142		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-44,629	248,146		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-44,629	834,398		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.32	611	2,100	672		2.00
3.00	Nurse Practitioner	0.39	739	2,100	819		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.71	1,350		1,491	1,491	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.71	1,350			1,491	8.00
9.00	Physician Services Under Agreements		229			229	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)					235,647	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					53,856	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					289,503	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.813971	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					301,078	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					213,312	15.00
16.00	Total overhead (sum of lines 14 and 15)					514,390	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					514,390	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					418,699	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					654,346	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/27/2024 2:41 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.95	4,428	4,200	3,990		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.64	2,173	2,100	1,344		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	6,601		5,334	6,601	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.59	6,601			6,601	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)					586,252	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)					586,252	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)					248,146	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					490,169	15.00
16.00	Total overhead (sum of lines 14 and 15)					738,315	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					738,315	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					738,315	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,324,567	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 2:41 pm
	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)			654,346	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			18,957	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			635,389	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,491	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			229	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,720	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			369.41	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	278.65	278.65		8.00
9.00	Rate for Program covered visits (see instructions)	278.65	278.65		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	50	86		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	13,933	23,964		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	37,897		16.00
16.01	Total program charges (see instructions)(from contractor's records)		31,988		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,105		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,602		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.)		18,976		16.04
16.05	Total program cost (see instructions)	0	28,578		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,575		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,862		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		28,578		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,338		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		30,916		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)		30,916		26.00
26.01	Sequestration adjustment (see instructions)		618		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		26,846		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,452		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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 2:41 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,324,567	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		56,290	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,268,277	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,601	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,601	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		192.13	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	229.53	229.53	8.00
9.00	Rate for Program covered visits (see instructions)	192.13	192.13	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	231	818	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	44,382	157,162	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	201,544	16.00
16.01	Total program charges (see instructions)(from contractor's records)		278,444	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		86,173	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		62,374	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.)		95,956	16.04
16.05	Total program cost (see instructions)	0	158,330	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,225	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,609	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		158,330	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,557	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		169,887	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)		169,887	26.00
26.01	Sequestration adjustment (see instructions)		3,398	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		179,047	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-12,558	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: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 2:41 pm

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)	199,438	199,438	199,438	199,438	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001374	0.009959	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	274	1,986	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,778	2,789	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,052	4,775	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	235,647	235,647	235,647	235,647	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	418,699	418,699	418,699	418,699	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008708	0.020263	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,646	8,484	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,698	13,259	0	0	10.00
11.00	Total number of injections/infusions (from your records)	12	87	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	474.83	152.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	6	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,424	914	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)		18,957	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)		2,338	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 2:41 pm

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)	530,804	530,804	530,804	530,804	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002671	0.013406	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,418	7,116	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,852	8,528	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,270	15,644	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	586,252	586,252	586,252	586,252	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	738,315	738,315	738,315	738,315	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015812	0.026685	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,674	19,702	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,944	35,346	0	0	10.00
11.00	Total number of injections/infusions (from your records)	53	266	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	395.17	132.88	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	84	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)	395	11,162	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		56,290	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)		11,557	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 2:41 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		26,846	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)		26,846	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		3,452	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		30,298	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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 2:41 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		179,047	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)		179,047	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		12,558	6.02
7.00	Total Medicare program liability (see instructions)		166,489	7.00

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