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: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/28/2024 11:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/28/2024 Time: 11:18 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Ralph Mercuri		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	Ralph Mercuri			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	295,493	-13,890	0	-843,687	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	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		281		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-21,553		0	10.01
10.02	RURAL HEALTH CLINIC III	0		350,820		0	10.02
200.00	TOTAL	0	295,493	315,658	0	-843,687	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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 11:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2451 INTELLIPLEX DR	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IN	Zip Code: 46176-	County: SHELBY	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	MAJOR HOSPITAL	150097	26900	1	07/01/1966	N	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MHP PEDIATRICS	158529	99915		01/29/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MHP OB/GYN	158531	99915		01/29/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MHP FAMILY & INTERNAL MEDICINE	158532	99915		01/29/2018	N	N	N	15.02
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	8		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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.	579	44	0	0	1,908	73	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.	1		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.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		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

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

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

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

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

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

		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

		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

		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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 11:18 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	473,681	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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		140.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 11:18 am

		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

		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	02/20/2024	Y	02/20/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 11:18 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	KYLE	SMITH	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.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2024 11:18 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	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)		46	16,790	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		46				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

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	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)	2,311	579	7,442			1.00
2.00	HMO and other (see instructions)	2,925	1,952				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,311	579	7,442			7.00
8.00	INTENSIVE CARE UNIT	379	0	1,692			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)	2,690	579	9,134	0.00	735.81	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			2			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	55	881	23,248	0.00	28.52	26.00
26.01	RURAL HEALTH CLINIC II	204	116	8,387	0.00	11.33	26.01
26.02	RURAL HEALTH CLINIC III	13,772	749	68,195	0.00	109.56	26.02
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	885.22	27.00
28.00	Observation Bed Days		7	819			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	73	102			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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 11:18 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	715	151	2,375	1.00
2.00	HMO and other (see instructions)			676	767		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	715	151	2,375	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
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2024 11:18 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	72,295,748	-395,879	71,899,869	1,823,723.00	39.42	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		650,040	0	650,040	3,243.00	200.44	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,600,160	0	2,600,160	12,973.00	200.43	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		8,378,383	0	8,378,383	308,416.00	27.17	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,734,509	106,541	3,841,050	63,698.00	60.30	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		458,642	0	458,642	6,050.00	75.81	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		303,745	0	303,745	1,619.00	187.61	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,685,111	0	14,685,111			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		765,893	0	765,893			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		73,448	0	73,448			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		293,801	0	293,801			23.00
24.00	Wage-related costs (RHC/FQHC)		2,691,864	0	2,691,864			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	661,361	-6,972	654,389	10,528.00	62.16	26.00
27.00	Administrative & General	5.00	11,355,044	-162,813	11,192,231	278,427.00	40.20	27.00
28.00	Administrative & General under contract (see inst.)		891,945	0	891,945	3,870.00	230.48	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,590,426	0	1,590,426	48,389.00	32.87	30.00
31.00	Laundry & Linen Service	8.00	3,468	-131	3,337	424.00	7.87	31.00
32.00	Housekeeping	9.00	1,704,547	-6,932	1,697,615	81,180.00	20.91	32.00
33.00	Housekeeping under contract (see instructions)		408,938	0	408,938	6,240.00	65.53	33.00
34.00	Dietary	10.00	1,091,650	-858,273	233,377	11,632.00	20.06	34.00
35.00	Dietary under contract (see instructions)		963,365	0	963,365	8,320.00	115.79	35.00
36.00	Cafeteria	11.00	0	852,906	852,906	43,716.00	19.51	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	856,596	-8,397	848,199	19,723.00	43.01	38.00
39.00	Central Services and Supply	14.00	349,533	-349,533	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,445,852	0	1,445,852	27,909.00	51.81	40.00
41.00	Medical Records & Medical Records Library	16.00	1,716,920	-6,642	1,710,278	58,303.00	29.33	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/28/2024 11:18 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		63,581,453	-395,879	63,185,574	1,520,764.00	41.55	1.00
2.00	Excluded area salaries (see instructions)		3,734,509	106,541	3,841,050	63,698.00	60.30	2.00
3.00	Subtotal salaries (line 1 minus line 2)		59,846,944	-502,420	59,344,524	1,457,066.00	40.73	3.00
4.00	Subtotal other wages & related costs (see inst.)		762,387	0	762,387	7,669.00	99.41	4.00
5.00	Subtotal wage-related costs (see inst.)		14,758,559	0	14,758,559	0.00	24.87	5.00
6.00	Total (sum of lines 3 thru 5)		75,367,890	-502,420	74,865,470	1,464,735.00	51.11	6.00
7.00	Total overhead cost (see instructions)		23,039,645	-546,787	22,492,858	598,661.00	37.57	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2024 11:18 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3,459,780	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	9,625,397	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	56,740	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	76,224	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	188,169	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	98,074	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,996,783	17.00
18.00	Medicare Taxes - Employers Portion Only	1,004,397	18.00
19.00	Unemployment Insurance	2,938	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,615	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,510,117	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	458,642	18,510,117	1.00
2.00	Hospital	458,642	18,510,117	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/28/2024 11:18 am

RHC I

		1.00	
	Clinic Address and Identification		
1.00	Street	2451 INTELLIPLEX DRIVE, SUITE 240	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IN	46176	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			07:30	17:00	07:30	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 11:18 am
		RHC I	

		County		
		4.00		
2.00	City, State, ZIP Code, County	SHELBY		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	07:30	17:00	07:30	17:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 11:18 am
		RHC II	

		1.00	
	Clinic Address and Identification		
1.00	Street	2451 INTELLIPLEX DRIVE, SUITE 230	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IN	46176	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 11:18 am
		RHC II	

			County		
			4.00		
2.00	City, State, ZIP Code, County		SHELBY		2.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 11:18 am
		RHC III	

					1.00		
	Clinic Address and Identification						
1.00	Street				2451 INTELLIPLEX DRIVE, SUITE 260		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		SHELBYVILLE		IN	46176	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			07:00	17:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/28/2024 11:18 am
		RHC III	

			County		
			4.00		
2.00	City, State, ZIP Code, County		SHLEBY		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	07:00	17:00	07:00	17:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 11:18 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.253803	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	21,495,707	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	112,660,279	6.00
7.00	Medicaid cost (line 1 times line 6)	28,593,517	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	7,097,810	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)	7,097,810	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)	5,440,890	408,240	5,849,130	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,380,914	403,452	1,784,366	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)	1,380,914	403,452	1,784,366	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)	6,417	25.01
26.00	Bad debt amount (see instructions)	7,441,516	26.00
27.00	Medicare reimbursable bad debts (see instructions)	155,233	27.00
27.01	Medicare allowable bad debts (see instructions)	238,821	27.01
28.00	Non-Medicare bad debt amount (see instructions)	7,202,695	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,911,654	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,696,020	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,793,830	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 11:18 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.205844	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)	5,440,890	408,240	5,849,130	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,119,975	403,144	1,523,119	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)	1,119,975	403,144	1,523,119	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)	6,417	25.01
26.00	Bad debt amount (see instructions)	7,441,516	26.00
27.00	Medicare reimbursable bad debts (see instructions)	142,297	27.00
27.01	Medicare allowable bad debts (see instructions)	218,919	27.01
28.00	Non-Medicare bad debt amount (see instructions)	7,222,597	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,563,350	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,086,469	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,086,469	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		17,477,590	17,477,590	0	17,477,590	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	661,361	13,559,160	14,220,521	0	14,220,521	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,355,044	25,379,592	36,734,636	-231,459	36,503,177	5.00
7.00	00700	OPERATION OF PLANT	1,590,426	2,482,755	4,073,181	0	4,073,181	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,468	339,922	343,390	0	343,390	8.00
9.00	00900	HOUSEKEEPING	1,704,547	1,029,314	2,733,861	0	2,733,861	9.00
10.00	01000	DIETARY	1,091,650	1,776,644	2,868,294	-2,250,820	617,474	10.00
11.00	01100	CAFETERIA	0	0	0	2,250,820	2,250,820	11.00
13.00	01300	NURSING ADMINISTRATION	856,596	446,399	1,302,995	0	1,302,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	349,533	514,711	864,244	-861,153	3,091	14.00
15.00	01500	PHARMACY	1,445,852	13,788,668	15,234,520	0	15,234,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,716,920	642,551	2,359,471	0	2,359,471	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,990,099	1,556,539	8,546,638	22,096	8,568,734	30.00
31.00	03100	INTENSIVE CARE UNIT	1,963,432	416,930	2,380,362	0	2,380,362	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,428,610	6,815,192	10,243,802	-2,946,138	7,297,664	50.00
53.00	05300	ANESTHESIOLOGY	3,437,925	260,244	3,698,169	48,060	3,746,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,832,394	2,326,797	6,159,191	0	6,159,191	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,956,897	1,294,001	3,250,898	0	3,250,898	56.01
57.00	05700	CT SCAN	605,562	1,323,373	1,928,935	0	1,928,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	591,422	102,106	693,528	0	693,528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,501,179	4,752,861	7,254,040	0	7,254,040	60.00
65.00	06500	RESPIRATORY THERAPY	1,709,847	238,183	1,948,030	0	1,948,030	65.00
65.01	06501	SLEEP LAB	518,011	104,649	622,660	0	622,660	65.01
66.00	06600	PHYSICAL THERAPY	2,522,009	292,330	2,814,339	0	2,814,339	66.00
69.00	06900	ELECTROCARDIOLOGY	854,356	1,861,823	2,716,179	0	2,716,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,439,579	3,439,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,725,982	1,498,181	3,224,163	158,476	3,382,639	88.00
88.01	08801	RURAL HEALTH CLINIC II	684,049	2,197,331	2,881,380	-74,811	2,806,569	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,668,323	7,081,627	14,749,950	0	14,749,950	88.02
90.00	09000	CLINIC	1,796,370	676,088	2,472,458	0	2,472,458	90.00
91.00	09100	EMERGENCY	3,393,997	2,137,680	5,531,677	345,616	5,877,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,605,378	270,241	1,875,619	0	1,875,619	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,561,239	112,643,482	181,204,721	-99,734	181,104,987	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	238,620	935,054	1,173,674	-48,060	1,125,614	190.02
190.03	19003	MEDWORKS PHARM	0	5,123	5,123	0	5,123	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	231,459	231,459	190.05
190.06	19006	YMCA/WELLNESS CENTER	15,784	43,626	59,410	0	59,410	190.06
190.07	19007	I-74 CAMPUS	0	91,735	91,735	0	91,735	190.07
190.08	19008	RAMPART	88,717	73,945	162,662	0	162,662	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	-717	33,155	32,438	0	32,438	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	44,978	37,825	82,803	0	82,803	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	51,857	56,459	108,316	0	108,316	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	2,978,720	490,033	3,468,753	-83,665	3,385,088	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	-10,092	-10,092	0	-10,092	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	3,277	934	4,211	0	4,211	192.05
194.00	07950	UNAVIE	313,273	102,648	415,921	0	415,921	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	72,295,748	114,503,927	186,799,675	0	186,799,675	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,460,295	14,017,295	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,618	14,204,903	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,765,067	20,738,110	5.00
7.00	00700	OPERATION OF PLANT	0	4,073,181	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	343,390	8.00
9.00	00900	HOUSEKEEPING	0	2,733,861	9.00
10.00	01000	DIETARY	-38,159	579,315	10.00
11.00	01100	CAFETERIA	-513,369	1,737,451	11.00
13.00	01300	NURSING ADMINISTRATION	-1,732	1,301,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,091	14.00
15.00	01500	PHARMACY	0	15,234,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,359,471	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-4,654	8,564,080	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,380,362	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	7,297,664	50.00
53.00	05300	ANESTHESIOLOGY	-3,527,408	218,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-666,737	5,492,454	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	-259,677	2,991,221	56.01
57.00	05700	CT SCAN	-930,909	998,026	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	693,528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-140,718	7,113,322	60.00
65.00	06500	RESPIRATORY THERAPY	-1,250	1,946,780	65.00
65.01	06501	SLEEP LAB	0	622,660	65.01
66.00	06600	PHYSICAL THERAPY	-82,703	2,731,636	66.00
69.00	06900	ELECTROCARDIOLOGY	-62,428	2,653,751	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,439,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	827,908	4,210,547	88.00
88.01	08801	RURAL HEALTH CLINIC II	-1,229,045	1,577,524	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,693,289	17,443,239	88.02
90.00	09000	CLINIC	48,898	2,521,356	90.00
91.00	09100	EMERGENCY	-1,265,484	4,611,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,875,619	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-24,395,158	156,709,829	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	UNUSED	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	1,125,614	190.02
190.03	19003	MEDWORKS PHARM	0	5,123	190.03
190.04	19004	FOR FUTURE USE	0	0	190.04
190.05	19005	MARKETING	0	231,459	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	59,410	190.06
190.07	19007	I-74 CAMPUS	0	91,735	190.07
190.08	19008	RAMPART	0	162,662	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	32,438	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	82,803	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.12
190.16	19016	RENOVO	0	108,316	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	3,385,088	192.01
192.02	19202	UNUSED	0	0	192.02
192.03	19203	UNUSED	0	0	192.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.04	19204	MAJ MAJOR PULMONOLOGY	0	-10,092	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	4,211	192.05
194.00	07950	UNAVIE	0	415,921	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,395,158	162,404,517	200.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 11:18 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	852,906	1,397,914	1.00
	0		852,906	1,397,914	
	B - CS&R OTHER				
1.00	ADULTS & PEDIATRICS	30.00	8,889	13,207	1.00
2.00	OPERATING ROOM	50.00	198,511	294,930	2.00
3.00	EMERGENCY	91.00	139,042	206,574	3.00
	0		346,442	514,711	
	C - MARKETING				
1.00	MARKETING	190.05	115,690	115,769	1.00
	0		115,690	115,769	
	D - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	133,392	3,306,187	1.00
	0		133,392	3,306,187	
	E - RHC RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	0	83,665	1.00
	0		0	83,665	
	F - SHORT TERM DISABILITY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,972	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	47,123	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	131	3.00
4.00	HOUSEKEEPING	9.00	0	6,932	4.00
5.00	DIETARY	10.00	0	5,367	5.00
6.00	NURSING ADMINISTRATION	13.00	0	8,397	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,091	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,642	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	30,215	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	7,339	10.00
11.00	OPERATING ROOM	50.00	0	19,825	11.00
12.00	ANESTHESIOLOGY	53.00	0	85,618	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,890	13.00
14.00	ONCOLOGY	56.01	0	4,386	14.00
15.00	CT SCAN	57.00	0	6,759	15.00
16.00	LABORATORY	60.00	0	9,507	16.00
17.00	RESPIRATORY THERAPY	65.00	0	12,544	17.00
18.00	SLEEP LAB	65.01	0	15,827	18.00
19.00	PHYSICAL THERAPY	66.00	0	16,924	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	7,970	20.00
21.00	RURAL HEALTH CLINIC	88.00	0	11,424	21.00
22.00	RURAL HEALTH CLINIC II	88.01	0	3,504	22.00
23.00	RURAL HEALTH CLINIC III	88.02	0	35,166	23.00
24.00	CLINIC	90.00	0	7,728	24.00
25.00	EMERGENCY	91.00	0	7,343	25.00
26.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	17,106	26.00
27.00	MEDICAL SPECIALITIES	190.02	0	1,430	27.00
28.00	UNAVIE	194.00	0	7,719	28.00
	0		0	395,879	
	G - PAIN MANAGEMENT MEDICAL DIRECTOR				
1.00	ANESTHESIOLOGY	53.00	0	48,060	1.00
	0		0	48,060	
	H - SOCIAL SERVICES RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	74,811	0	1.00
	TOTALS		74,811	0	
500.00	Grand Total: Increases		1,523,241	5,862,185	500.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 11:18 am

	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	852,906	1,397,914	0		1.00
	0		852,906	1,397,914			
	B - CS&R OTHER						
1.00	CENTRAL SERVICES & SUPPLY	14.00	346,442	514,711	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		346,442	514,711			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	115,690	115,769	0		1.00
	0		115,690	115,769			
	D - IMPLANTABLE DEVICES RECLASS						
1.00	OPERATING ROOM	50.00	133,392	3,306,187	0		1.00
	0		133,392	3,306,187			
	E - RHC RECLASS						
1.00	HOSPITALIST	192.01	0	83,665	0		1.00
	0		0	83,665			
	F - SHORT TERM DISABILITY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,972	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	47,123	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	131	0	0		3.00
4.00	HOUSEKEEPING	9.00	6,932	0	0		4.00
5.00	DIETARY	10.00	5,367	0	0		5.00
6.00	NURSING ADMINISTRATION	13.00	8,397	0	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	3,091	0	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	6,642	0	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	30,215	0	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	7,339	0	0		10.00
11.00	OPERATING ROOM	50.00	19,825	0	0		11.00
12.00	ANESTHESIOLOGY	53.00	85,618	0	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	2,890	0	0		13.00
14.00	ONCOLOGY	56.01	4,386	0	0		14.00
15.00	CT SCAN	57.00	6,759	0	0		15.00
16.00	LABORATORY	60.00	9,507	0	0		16.00
17.00	RESPIRATORY THERAPY	65.00	12,544	0	0		17.00
18.00	SLEEP LAB	65.01	15,827	0	0		18.00
19.00	PHYSICAL THERAPY	66.00	16,924	0	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	7,970	0	0		20.00
21.00	RURAL HEALTH CLINIC	88.00	11,424	0	0		21.00
22.00	RURAL HEALTH CLINIC II	88.01	3,504	0	0		22.00
23.00	RURAL HEALTH CLINIC III	88.02	35,166	0	0		23.00
24.00	CLINIC	90.00	7,728	0	0		24.00
25.00	EMERGENCY	91.00	7,343	0	0		25.00
26.00	OBSERVATION BEDS (DISTINCT PART)	92.01	17,106	0	0		26.00
27.00	MEDICAL SPECIALITIES	190.02	1,430	0	0		27.00
28.00	UNAVIE	194.00	7,719	0	0		28.00
	0		395,879	0			
	G - PAIN MANAGEMENT MEDICAL DIRECTOR						
1.00	MEDICAL SPECIALITIES	190.02	0	48,060	0		1.00
	0		0	48,060			
	H - SOCIAL SERVICES RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	74,811	0	0		1.00
	TOTALS		74,811	0			
500.00	Grand Total: Decreases		1,919,120	5,466,306			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2024 11:18 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,900,662	0	0	0	0	1.00
2.00	Land Improvements	12,792,242	214,418	0	214,418	0	2.00
3.00	Buildings and Fixtures	147,116,985	3,409,024	0	3,409,024	0	3.00
4.00	Building Improvements	264,162	0	0	0	0	4.00
5.00	Fixed Equipment	6,966,805	28,609	0	28,609	0	5.00
6.00	Movable Equipment	61,008,182	6,461,608	0	6,461,608	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	231,049,038	10,113,659	0	10,113,659	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	231,049,038	10,113,659	0	10,113,659	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,900,662	0	1.00
2.00	Land Improvements	13,006,660	0	2.00
3.00	Buildings and Fixtures	150,526,009	0	3.00
4.00	Building Improvements	264,162	0	4.00
5.00	Fixed Equipment	6,995,414	0	5.00
6.00	Movable Equipment	67,469,790	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	241,162,697	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	241,162,697	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	17,477,590	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	17,477,590	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	17,477,590	1.00
3.00	Total (sum of lines 1-2)	0	17,477,590	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	Gross Assets (COMPUTATION OF RATIOS)	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions) (ALLOCATION OF OTHER CAPITAL)	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	173,692,907	0	173,692,907	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	173,692,907	0	173,692,907	1.000000	0	3.00

	Cost Center Description	Taxes (ALLOCATION OF OTHER CAPITAL)	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation (SUMMARY OF CAPITAL)	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	17,477,590	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,477,590	0	3.00

	Cost Center Description	Interest (SUMMARY OF CAPITAL)	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	-3,460,295	0	0	0	14,017,295	1.00
3.00	Total (sum of lines 1-2)	-3,460,295	0	0	0	14,017,295	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,460,295	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,129	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,791,129			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	3,626,425			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-510,765	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-2,604	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
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	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MAJ OTHER REVENUES CASH OVER/SHORT	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	MAJ TECHNOLOGY SERV CONTRACT LABOR	B	-247,302	ADMINISTRATIVE & GENERAL	5.00	9	35.00
36.00	MAJ PATIENT ACCESS CONTRACT LABOR	B	-8,333	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MAJ ACCOUNTING CONTRACT LABOR	B	-131,864	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MAJ ADMINISTRATION CONTRACT LABOR	B	-223,336	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MH EDUCATION CLASS REVENUE	B	-30,622	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MAJ ACCOUNTING VENDOR REBATES	B	-64,865	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MAJ OTHER REVENUES PURCHASE DISCOUNT	B	-3,567	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MAJ CL NUTR-DIAB ED OTHER INCOME	B	-1,091	NURSING ADMINISTRATION	13.00	0	44.00
44.01	MAJ OTHER REVENUES REAPPOINTMENT FEE	B	-15,100	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	MAJ PATIENT FINANCI PHYSICIAN BILLIN	B	-761,159	ADMINISTRATIVE & GENERAL	5.00	0	44.02
44.03	MAJ REHABILATION SE CONTRACT LABOR	B	-73,824	PHYSICAL THERAPY	66.00	0	44.03
45.00	MAJ CARDIAC DISEASE CONTRACT LABOR	B	-61,776	ELECTROCARDIOLOGY	69.00	0	45.00
45.01	MH MHP FIM OTHER INCOME	B	-45	RURAL HEALTH CLINIC III	88.02	0	45.01
45.02	MAJ OTHER REVENUES OTHER INCOME	B	-1,092	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	MOW OFFSET	A	-38,159	DIETARY	10.00	0	45.03
45.04	PROMOTIONAL GIFTS	A	-1,250	RESPIRATORY THERAPY	65.00	0	45.04
45.05	PROMOTIONAL GIFTS	A	-2,365	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	PROMOTIONAL GIFTS	A	-641	NURSING ADMINISTRATION	13.00	0	45.06
45.07	PROMOTIONAL GIFTS	A	-4,654	ADULTS & PEDIATRICS	30.00	0	45.07
45.08	PROMOTIONAL GIFTS	A	-2,543	RADIOLOGY-DIAGNOSTIC	54.00	0	45.08
45.09	PROMOTIONAL GIFTS	A	-12,546	ONCOLOGY	56.01	0	45.09
45.10	PROMOTIONAL GIFTS	A	-8,879	PHYSICAL THERAPY	66.00	0	45.10
45.11	PROMOTIONAL GIFTS	A	-536	RURAL HEALTH CLINIC	88.00	0	45.11
45.12	PROMOTIONAL GIFTS	A	-3,062	CLINIC	90.00	0	45.12
45.13	PROMOTIONAL GIFTS	A	-1,692	RURAL HEALTH CLINIC II	88.01	0	45.13
45.14	PROMOTIONAL GIFTS	A	-652	ELECTROCARDIOLOGY	69.00	0	45.14
45.15	PROMOTIONAL GIFTS	A	-333	EMERGENCY	91.00	0	45.15
45.16	MAJ WOUND CARE ADVERTISING	A	-40	CLINIC	90.00	0	45.16
45.17	MAJ MHP FIM ADVERTISING	A	-1,104	RURAL HEALTH CLINIC III	88.02	0	45.17
45.18	MAJ COMMUNITY OUTRE ADVERTISING	A	-3,158	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	MAJ MARKETING ADVERTISING	A	-20,249	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	MAJ ADMINISTRATION ADVERTISING	A	-850	ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	COMMUNITY OUTREACH	A	-549,052	ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.22	HAF EXPENSE	A	-7,931,912	ADMINISTRATIVE & GENERAL	5.00	0	45.22
45.23	NON-ALLOWABLE RHC	A	-27,304	RURAL HEALTH CLINIC II	88.01	0	45.23
45.24	LOBBYING % OF DUES	A	-11,190	ADMINISTRATIVE & GENERAL	5.00	0	45.24
45.25	MISC. PURCHASED SERVICES	A	-5,751,182	ADMINISTRATIVE & GENERAL	5.00	0	45.25
45.26	NON-ALLOWABLE OB/GYN RHC	A	-1,245,326	RURAL HEALTH CLINIC II	88.01	0	45.26
45.27	UROLOGY RHC	A	-6,266	RURAL HEALTH CLINIC III	88.02	0	45.27
45.28	FOUNDATION OFFSET	A	-3,740	ADMINISTRATIVE & GENERAL	5.00	0	45.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,395,158				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 Date/Time Prepared: 5/28/2024 11:18 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

(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: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/28/2024 11:18 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	88.00	RURAL HEALTH CLINIC	MHP PEDS RHC	1,771,197	942,753	1.00
2.00	88.01	RURAL HEALTH CLINIC II	MHP OB/GYN RHC	633,993	588,716	2.00
3.00	88.02	RURAL HEALTH CLINIC III	MHP FAM PRACT RHC	7,123,970	4,423,266	3.00
4.00	90.00	CLINIC	UROLOGY	52,000	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,581,160	5,954,735	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	MMG	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/28/2024 11:18 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	828,444	0	1.00
2.00	45,277	0	2.00
3.00	2,700,704	0	3.00
4.00	52,000	0	4.00
5.00	3,626,425		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.

	Type of Business	
6.00	PHYSICIAN GROUP	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2024 11:18 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	32,313	0	32,313	179,000	194	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	3,921,382	3,100,058	821,324	239,400	3,423	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	664,194	664,194	0	271,900	0	4.00
5.00	56.01	ONCOLOGY	266,739	241,739	25,000	271,900	150	5.00
6.00	57.00	CT SCAN	930,909	930,909	0	0	0	6.00
7.00	60.00	LABORATORY	161,867	26,398	135,469	260,300	169	7.00
8.00	91.00	EMERGENCY	1,308,524	1,246,024	62,500	179,000	504	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,285,928	6,209,322	1,076,606		4,440	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	16,695	835	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	393,974	19,699	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	56.01	ONCOLOGY	19,608	980	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	21,149	1,057	0	0	0	7.00
8.00	91.00	EMERGENCY	43,373	2,169	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			494,799	24,740	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	16,695	15,618	15,618		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		2.00
3.00	53.00	ANESTHESIOLOGY	0	393,974	427,350	3,527,408		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	664,194		4.00
5.00	56.01	ONCOLOGY	0	19,608	5,392	247,131		5.00
6.00	57.00	CT SCAN	0	0	0	930,909		6.00
7.00	60.00	LABORATORY	0	21,149	114,320	140,718		7.00
8.00	91.00	EMERGENCY	0	43,373	19,127	1,265,151		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	494,799	581,807	6,791,129		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 11:18 am

		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	14,017,295	14,017,295				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,204,903	43,171	14,248,074			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,738,110	757,063	2,261,934	23,757,107	23,757,107	5.00
7.00	00700	OPERATION OF PLANT	4,073,181	886,982	329,788	5,289,951	906,364	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	343,390	48,692	719	392,801	67,301	8.00
9.00	00900	HOUSEKEEPING	2,733,861	111,738	353,451	3,199,050	548,116	9.00
10.00	01000	DIETARY	579,315	59,108	49,505	687,928	117,868	10.00
11.00	01100	CAFETERIA	1,737,451	211,219	176,857	2,125,527	364,181	11.00
13.00	01300	NURSING ADMINISTRATION	1,301,263	95,949	177,622	1,574,834	269,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,091	119,135	0	122,226	20,942	14.00
15.00	01500	PHARMACY	15,234,520	99,003	299,809	15,633,332	2,678,568	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,359,471	82,257	356,017	2,797,745	479,357	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,564,080	933,024	1,451,313	10,948,417	1,875,869	30.00
31.00	03100	INTENSIVE CARE UNIT	2,380,362	183,653	407,133	2,971,148	509,068	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,297,664	1,040,124	724,820	9,062,608	1,552,760	50.00
53.00	05300	ANESTHESIOLOGY	218,821	18,439	175,479	412,739	70,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,492,454	371,465	794,678	6,658,597	1,140,864	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	2,991,221	733,655	405,778	4,130,654	707,734	56.01
57.00	05700	CT SCAN	998,026	54,507	125,568	1,178,101	201,852	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	693,528	55,170	122,636	871,334	149,292	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,113,322	202,276	518,639	7,834,237	1,342,295	60.00
65.00	06500	RESPIRATORY THERAPY	1,946,780	169,520	355,230	2,471,530	423,465	65.00
65.01	06501	SLEEP LAB	622,660	105,996	107,414	836,070	143,250	65.01
66.00	06600	PHYSICAL THERAPY	2,731,636	434,548	522,959	3,689,143	632,087	66.00
69.00	06900	ELECTROCARDIOLOGY	2,653,751	139,966	177,158	2,970,875	509,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,439,579	0	27,660	3,467,239	594,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,210,547	269,407	357,896	4,837,850	828,903	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,577,524	159,178	141,843	1,878,545	321,864	88.01
88.02	08802	RURAL HEALTH CLINIC III	17,443,239	888,123	1,590,088	19,921,450	3,413,226	88.02
90.00	09000	CLINIC	2,521,356	279,197	372,492	3,173,045	543,660	90.00
91.00	09100	EMERGENCY	4,611,809	504,770	732,861	5,849,440	1,002,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,875,619	260,758	332,888	2,469,265	423,076	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,709,829	9,318,093	13,450,235	151,212,788	21,837,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,640	0	27,640	4,736	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	1,125,614	255,826	49,480	1,430,920	245,170	190.02
190.03	19003	MEDWORKS PHARM	5,123	220,825	0	225,948	38,713	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	231,459	20,242	23,989	275,690	47,236	190.05
190.06	19006	YMCA/WELLNESS CENTER	59,410	2,917,989	3,273	2,980,672	510,699	190.06
190.07	19007	I-74 CAMPUS	91,735	0	0	91,735	15,718	190.07
190.08	19008	RAMPART	162,662	404,957	18,396	586,015	100,406	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	32,438	328,551	0	360,989	61,851	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	82,803	11,041	9,327	103,171	17,677	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	108,316	225,868	10,753	344,937	59,100	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 11:18 am

		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	
192.01	19201	HOSPITALIST	3,385,088	8,244	617,661	4,010,993	687,232	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	-10,092	0	0	-10,092	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	4,211	0	0	4,211	722	192.05
194.00	07950	UNAVIE	415,921	278,019	64,960	758,900	130,028	194.00
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)	162,404,517	14,017,295	14,248,074	162,404,517	23,757,107	202.00

		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	6,196,315					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,470	484,572				8.00
9.00	00900	HOUSEKEEPING	56,152	0	3,803,318			9.00
10.00	01000	DIETARY	29,704	0	18,473	853,973		10.00
11.00	01100	CAFETERIA	106,145	0	66,011	0	2,661,864	11.00
13.00	01300	NURSING ADMINISTRATION	48,218	0	29,986	0	40,532	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,870	0	37,233	0	0	14.00
15.00	01500	PHARMACY	49,753	0	30,941	0	57,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,337	0	25,707	0	119,817	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	468,879	188,666	291,593	697,528	333,641	30.00
31.00	03100	INTENSIVE CARE UNIT	92,292	0	57,396	156,445	97,941	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	522,700	74,490	325,065	0	178,125	50.00
53.00	05300	ANESTHESIOLOGY	9,266	0	5,763	0	39,242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,675	59,148	116,092	0	172,550	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	368,689	17,102	229,286	0	93,999	56.01
57.00	05700	CT SCAN	27,392	0	17,035	0	22,867	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,725	0	17,242	0	27,357	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	101,651	0	63,216	0	163,395	60.00
65.00	06500	RESPIRATORY THERAPY	85,190	6,352	52,979	0	85,906	65.00
65.01	06501	SLEEP LAB	53,267	0	33,126	0	0	65.01
66.00	06600	PHYSICAL THERAPY	218,376	18,962	135,807	0	107,217	66.00
69.00	06900	ELECTROCARDIOLOGY	70,338	0	43,743	0	35,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	135,387	0	84,196	0	120,487	88.00
88.01	08801	RURAL HEALTH CLINIC II	79,993	0	49,747	0	47,949	88.01
88.02	08802	RURAL HEALTH CLINIC III	446,314	0	277,560	0	465,378	88.02
90.00	09000	CLINIC	140,307	0	87,256	0	73,898	90.00
91.00	09100	EMERGENCY	253,665	119,852	157,753	0	184,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	131,040	0	81,493	0	78,411	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,834,795	484,572	2,334,699	853,973	2,557,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,890	0	8,638	0	0	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	128,562	0	79,952	0	19,400	190.02
190.03	19003	MEDWORKS PHARM	110,973	0	69,013	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	10,173	0	6,326	0	5,890	190.05
190.06	19006	YMCA/WELLNESS CENTER	1,466,393	0	911,946	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	203,506	0	126,559	0	9,383	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	165,109	0	102,680	0	0	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	5,549	0	3,451	0	4,285	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	113,507	0	70,589	0	4,429	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	4,143	0	2,577	0	60,766	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.00	07950	UNAVIE	139,715	0	86,888	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,196,315	484,572	3,803,318	853,973	2,661,864	202.00

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & 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	1,963,397					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	240,271				14.00
15.00	01500	PHARMACY	0	0	18,449,949			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,463,963		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	321,045	0	0	99,780	15,225,418	30.00
31.00	03100	INTENSIVE CARE UNIT	94,243	0	0	37,107	4,015,640	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	171,401	132,149	0	579,772	12,599,070	50.00
53.00	05300	ANESTHESIOLOGY	37,760	0	0	4,477	579,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	233,481	8,567,407	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	90,450	0	0	185,150	5,823,064	56.01
57.00	05700	CT SCAN	0	0	0	236,476	1,683,723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	59,155	1,152,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	368,772	9,873,566	60.00
65.00	06500	RESPIRATORY THERAPY	82,663	0	0	65,485	3,273,570	65.00
65.01	06501	SLEEP LAB	24,220	0	0	24,820	1,114,753	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	68,427	4,870,019	66.00
69.00	06900	ELECTROCARDIOLOGY	33,890	0	0	122,545	3,785,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	108,122	0	88,300	4,269,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,449,949	510,104	18,960,053	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	115,938	0	0	33,122	6,155,883	88.00
88.01	08801	RURAL HEALTH CLINIC II	46,139	0	0	17,804	2,442,041	88.01
88.02	08802	RURAL HEALTH CLINIC III	447,814	0	0	133,461	25,105,203	88.02
90.00	09000	CLINIC	71,109	0	0	63,070	4,152,345	90.00
91.00	09100	EMERGENCY	177,964	0	0	481,092	8,226,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	75,451	0	0	51,563	3,310,299	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,790,087	240,271	18,449,949	3,463,963	145,185,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,019	0	0	0	59,923	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	18,667	0	0	0	1,922,671	190.02
190.03	19003	MEDWORKS PHARM	0	0	0	0	444,647	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	0	345,315	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0	0	5,869,710	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	107,453	190.07
190.08	19008	RAMPART	9,029	0	0	0	1,034,898	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	690,629	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	134,133	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	4,261	0	0	0	596,823	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	58,472	0	0	0	4,824,183	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	-10,092	192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	4,933	192.05
194.00	07950	UNAVIE	77,862	0	0	0	1,193,393	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,963,397	240,271	18,449,949	3,463,963	162,404,517	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 11:18 am

		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 SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	15,225,418	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,015,640	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	12,599,070	50.00
53.00	05300	ANESTHESIOLOGY	0	579,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,567,407	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	5,823,064	56.01
57.00	05700	CT SCAN	0	1,683,723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,152,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	9,873,566	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,273,570	65.00
65.01	06501	SLEEP LAB	0	1,114,753	65.01
66.00	06600	PHYSICAL THERAPY	0	4,870,019	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,785,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,269,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,960,053	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	6,155,883	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,442,041	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	25,105,203	88.02
90.00	09000	CLINIC	0	4,152,345	90.00
91.00	09100	EMERGENCY	0	8,226,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	3,310,299	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	145,185,898	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,923	190.00
190.01	19001	UNUSED	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	1,922,671	190.02
190.03	19003	MEDWORKS PHARM	0	444,647	190.03
190.04	19004	FOR FUTURE USE	0	0	190.04
190.05	19005	MARKETING	0	345,315	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	5,869,710	190.06
190.07	19007	I-74 CAMPUS	0	107,453	190.07
190.08	19008	RAMPART	0	1,034,898	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	690,629	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	134,133	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.12
190.16	19016	RENOVO	0	596,823	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	4,824,183	192.01
192.02	19202	UNUSED	0	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
192.03	19203	UNUSED	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	-10,092	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	4,933	192.05
194.00	07950	UNAVIE	0	1,193,393	194.00
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	162,404,517	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 11:18 am

		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	43,171	43,171	43,171		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	757,063	757,063	6,868	763,931	5.00
7.00	00700	OPERATION OF PLANT	0	886,982	886,982	999	29,142	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,692	48,692	2	2,164	8.00
9.00	00900	HOUSEKEEPING	0	111,738	111,738	1,070	17,624	9.00
10.00	01000	DIETARY	0	59,108	59,108	150	3,790	10.00
11.00	01100	CAFETERIA	0	211,219	211,219	536	11,710	11.00
13.00	01300	NURSING ADMINISTRATION	0	95,949	95,949	538	8,676	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	119,135	119,135	0	673	14.00
15.00	01500	PHARMACY	0	99,003	99,003	908	86,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	82,257	82,257	1,078	15,413	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	933,024	933,024	4,395	60,315	30.00
31.00	03100	INTENSIVE CARE UNIT	0	183,653	183,653	1,233	16,368	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,040,124	1,040,124	2,195	49,926	50.00
53.00	05300	ANESTHESIOLOGY	0	18,439	18,439	531	2,274	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	371,465	371,465	2,407	36,682	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	733,655	733,655	1,229	22,756	56.01
57.00	05700	CT SCAN	0	54,507	54,507	380	6,490	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	55,170	55,170	371	4,800	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	202,276	202,276	1,571	43,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	169,520	169,520	1,076	13,616	65.00
65.01	06501	SLEEP LAB	0	105,996	105,996	325	4,606	65.01
66.00	06600	PHYSICAL THERAPY	0	434,548	434,548	1,584	20,323	66.00
69.00	06900	ELECTROCARDIOLOGY	0	139,966	139,966	537	16,367	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	84	19,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	269,407	269,407	1,084	26,652	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	159,178	159,178	430	10,349	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	888,123	888,123	4,816	109,812	88.02
90.00	09000	CLINIC	0	279,197	279,197	1,128	17,480	90.00
91.00	09100	EMERGENCY	0	504,770	504,770	2,220	32,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	260,758	260,758	1,008	13,603	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,318,093	9,318,093	40,753	702,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,640	27,640	0	152	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	255,826	255,826	150	7,883	190.02
190.03	19003	MEDWORKS PHARM	0	220,825	220,825	0	1,245	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	20,242	20,242	73	1,519	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	2,917,989	2,917,989	10	16,421	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	505	190.07
190.08	19008	RAMPART	0	404,957	404,957	56	3,228	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	328,551	328,551	0	1,989	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	11,041	11,041	28	568	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	0	225,868	225,868	33	1,900	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	8,244	8,244	1,871	22,097	192.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 11:18 am

		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	
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	23	192.05
194.00	07950	UNAVIE	0	278,019	278,019	197	4,181	194.00
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	14,017,295	14,017,295	43,171	763,931	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	917,123					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,622	54,480				8.00
9.00	00900	HOUSEKEEPING	8,311	0	138,743			9.00
10.00	01000	DIETARY	4,396	0	674	68,118		10.00
11.00	01100	CAFETERIA	15,711	0	2,408	0	241,584	11.00
13.00	01300	NURSING ADMINISTRATION	7,137	0	1,094	0	3,679	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,861	0	1,358	0	0	14.00
15.00	01500	PHARMACY	7,364	0	1,129	0	5,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,118	0	938	0	10,874	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,399	21,211	10,637	55,639	30,280	30.00
31.00	03100	INTENSIVE CARE UNIT	13,660	0	2,094	12,479	8,889	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,365	8,375	11,858	0	16,166	50.00
53.00	05300	ANESTHESIOLOGY	1,372	0	210	0	3,561	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,630	6,650	4,235	0	15,660	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	54,570	1,923	8,364	0	8,531	56.01
57.00	05700	CT SCAN	4,054	0	621	0	2,075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,104	0	629	0	2,483	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	15,045	0	2,306	0	14,829	60.00
65.00	06500	RESPIRATORY THERAPY	12,609	714	1,933	0	7,797	65.00
65.01	06501	SLEEP LAB	7,884	0	1,208	0	0	65.01
66.00	06600	PHYSICAL THERAPY	32,322	2,132	4,954	0	9,731	66.00
69.00	06900	ELECTROCARDIOLOGY	10,411	0	1,596	0	3,196	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,039	0	3,071	0	10,935	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,840	0	1,815	0	4,352	88.01
88.02	08802	RURAL HEALTH CLINIC III	66,059	0	10,125	0	42,237	88.02
90.00	09000	CLINIC	20,767	0	3,183	0	6,707	90.00
91.00	09100	EMERGENCY	37,545	13,475	5,755	0	16,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	19,395	0	2,973	0	7,116	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	567,590	54,480	85,168	68,118	232,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,056	0	315	0	0	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	19,029	0	2,917	0	1,761	190.02
190.03	19003	MEDWORKS PHARM	16,425	0	2,518	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	1,506	0	231	0	535	190.05
190.06	19006	YMCA/WELLNESS CENTER	217,045	0	33,266	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	30,121	0	4,617	0	852	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	24,438	0	3,746	0	0	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	821	0	126	0	389	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	16,800	0	2,575	0	402	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	613	0	94	0	5,515	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	0	192.05

ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.00	07950	UNAVIE	20,679	0	3,170	0	0	194.00
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)	917,123	54,480	138,743	68,118	241,584	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & 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	117,073					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	130,027				14.00
15.00	01500	PHARMACY	0	0	199,733			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	116,678		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,143	0	0	3,362	1,207,405	30.00
31.00	03100	INTENSIVE CARE UNIT	5,619	0	0	1,250	245,245	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,220	71,515	0	19,507	1,307,251	50.00
53.00	05300	ANESTHESIOLOGY	2,252	0	0	151	28,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,866	472,595	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	5,393	0	0	6,238	842,659	56.01
57.00	05700	CT SCAN	0	0	0	7,967	76,094	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,993	69,550	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	12,424	291,610	60.00
65.00	06500	RESPIRATORY THERAPY	4,929	0	0	2,206	214,400	65.00
65.01	06501	SLEEP LAB	1,444	0	0	836	122,299	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	2,305	507,899	66.00
69.00	06900	ELECTROCARDIOLOGY	2,021	0	0	4,129	178,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	58,512	0	2,975	81,714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	199,733	17,186	216,919	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,913	0	0	1,116	339,217	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,751	0	0	600	191,315	88.01
88.02	08802	RURAL HEALTH CLINIC III	26,703	0	0	4,496	1,152,371	88.02
90.00	09000	CLINIC	4,240	0	0	2,125	334,827	90.00
91.00	09100	EMERGENCY	10,612	0	0	16,209	639,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,499	0	0	1,737	311,089	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,739	130,027	199,733	116,678	8,831,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	299	0	0	0	30,462	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	1,113	0	0	0	288,679	190.02
190.03	19003	MEDWORKS PHARM	0	0	0	0	241,013	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	0	24,106	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0	0	3,184,731	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	505	190.07
190.08	19008	RAMPART	538	0	0	0	444,369	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	358,724	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	12,973	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	254	0	0	0	247,832	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,487	0	0	0	41,921	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	0	192.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	23	192.05
194.00	07950	UNAVIE	4,643	0	0	0	310,889	194.00
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)	117,073	130,027	199,733	116,678	14,017,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 11:18 am

		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 SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,207,405		30.00
31.00	03100	INTENSIVE CARE UNIT	0	245,245		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,307,251		50.00
53.00	05300	ANESTHESIOLOGY	0	28,790		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	472,595		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	842,659		56.01
57.00	05700	CT SCAN	0	76,094		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	69,550		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	291,610		60.00
65.00	06500	RESPIRATORY THERAPY	0	214,400		65.00
65.01	06501	SLEEP LAB	0	122,299		65.01
66.00	06600	PHYSICAL THERAPY	0	507,899		66.00
69.00	06900	ELECTROCARDIOLOGY	0	178,223		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	81,714		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	216,919		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	339,217		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	191,315		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,152,371		88.02
90.00	09000	CLINIC	0	334,827		90.00
91.00	09100	EMERGENCY	0	639,596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	311,089		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,831,068		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,462		190.00
190.01	19001	UNUSED	0	0		190.01
190.02	19002	MEDICAL SPECIALITIES	0	288,679		190.02
190.03	19003	MEDWORKS PHARM	0	241,013		190.03
190.04	19004	FOR FUTURE USE	0	0		190.04
190.05	19005	MARKETING	0	24,106		190.05
190.06	19006	YMCA/WELLNESS CENTER	0	3,184,731		190.06
190.07	19007	I-74 CAMPUS	0	505		190.07
190.08	19008	RAMPART	0	444,369		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	358,724		190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.10
190.11	19011	MHP ADMIN BUILDING	0	12,973		190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.12
190.16	19016	RENOVO	0	247,832		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	41,921		192.01
192.02	19202	UNUSED	0	0		192.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
192.03	19203	UNUSED	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	23	192.05
194.00	07950	UNAVIE	0	310,889	194.00
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	14,017,295	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		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	380,861					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,173	68,712,302				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,570	10,908,215	-23,757,107	138,657,502		5.00
7.00	00700	OPERATION OF PLANT	24,100	1,590,426	0	5,289,951	335,018	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,323	3,468	0	392,801	1,323	8.00
9.00	00900	HOUSEKEEPING	3,036	1,704,547	0	3,199,050	3,036	9.00
10.00	01000	DIETARY	1,606	238,744	0	687,928	1,606	10.00
11.00	01100	CAFETERIA	5,739	852,906	0	2,125,527	5,739	11.00
13.00	01300	NURSING ADMINISTRATION	2,607	856,596	0	1,574,834	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	0	0	122,226	3,237	14.00
15.00	01500	PHARMACY	2,690	1,445,852	0	15,633,332	2,690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	1,716,920	0	2,797,745	2,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,351	6,999,068	0	10,948,417	25,351	30.00
31.00	03100	INTENSIVE CARE UNIT	4,990	1,963,432	0	2,971,148	4,990	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,261	3,495,500	0	9,062,608	28,261	50.00
53.00	05300	ANESTHESIOLOGY	501	846,263	0	412,739	501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,093	3,832,394	0	6,658,597	10,093	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	19,934	1,956,897	0	4,130,654	19,934	56.01
57.00	05700	CT SCAN	1,481	605,562	0	1,178,101	1,481	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,499	591,422	0	871,334	1,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,496	2,501,179	0	7,834,237	5,496	60.00
65.00	06500	RESPIRATORY THERAPY	4,606	1,713,124	0	2,471,530	4,606	65.00
65.01	06501	SLEEP LAB	2,880	518,011	0	836,070	2,880	65.01
66.00	06600	PHYSICAL THERAPY	11,807	2,522,009	0	3,689,143	11,807	66.00
69.00	06900	ELECTROCARDIOLOGY	3,803	854,356	0	2,970,875	3,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	133,392	0	3,467,239	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,320	1,725,982	0	4,837,850	7,320	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,325	684,049	0	1,878,545	4,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,131	7,668,323	0	19,921,450	24,131	88.02
90.00	09000	CLINIC	7,586	1,796,370	0	3,173,045	7,586	90.00
91.00	09100	EMERGENCY	13,715	3,534,278	0	5,849,440	13,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,085	1,605,378	0	2,469,265	7,085	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	253,180	64,864,663	-23,757,107	127,455,681	207,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0	0	27,640	751	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	6,951	238,620	0	1,430,920	6,951	190.02
190.03	19003	MEDWORKS PHARM	6,000	0	0	225,948	6,000	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	550	115,690	0	275,690	550	190.05
190.06	19006	YMCA/WELLNESS CENTER	79,284	15,784	0	2,980,672	79,284	190.06
190.07	19007	I-74 CAMPUS	0	0	0	91,735	0	190.07
190.08	19008	RAMPART	11,003	88,717	0	586,015	11,003	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	8,927	0	0	360,989	8,927	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	300	44,978	0	103,171	300	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	6,137	51,857	0	344,937	6,137	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		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	
192.01	19201	HOSPITALIST	224	2,978,720	0	4,010,993	224	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	10,092	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	4,211	0	192.05
194.00	07950	UNAVIE	7,554	313,273	0	758,900	7,554	194.00
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)	14,017,295	14,248,074		23,757,107	6,196,315	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.804228	0.207358		0.171337	18.495469	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		43,171		763,931	917,123	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000628		0.005509	2.737534	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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			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	403,767					8.00
9.00	00900	HOUSEKEEPING	0	330,659				9.00
10.00	01000	DIETARY	0	1,606	9,236			10.00
11.00	01100	CAFETERIA	0	5,739	0	1,295,267		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,607	0	19,723	992,874	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,237	0	0	0	14.00
15.00	01500	PHARMACY	0	2,690	0	27,909	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,235	0	58,303	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	157,205	25,351	7,544	162,350	162,350	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,990	1,692	47,658	47,658	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,068	28,261	0	86,676	86,676	50.00
53.00	05300	ANESTHESIOLOGY	0	501	0	19,095	19,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,285	10,093	0	83,963	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	14,250	19,934	0	45,740	45,740	56.01
57.00	05700	CT SCAN	0	1,481	0	11,127	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,499	0	13,312	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,496	0	79,508	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,293	4,606	0	41,802	41,802	65.00
65.01	06501	SLEEP LAB	0	2,880	0	0	12,248	65.01
66.00	06600	PHYSICAL THERAPY	15,800	11,807	0	52,172	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,803	0	17,138	17,138	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,320	0	58,629	58,629	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,325	0	23,332	23,332	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	24,131	0	226,455	226,455	88.02
90.00	09000	CLINIC	0	7,586	0	35,959	35,959	90.00
91.00	09100	EMERGENCY	99,866	13,715	0	89,995	89,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,085	0	38,155	38,155	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	403,767	202,978	9,236	1,244,586	905,232	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	0	2,538	190.00
190.01	19001	UNUSED	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	6,951	0	9,440	9,440	190.02
190.03	19003	MEDWORKS PHARM	0	6,000	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	550	0	2,866	0	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	79,284	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	11,003	0	4,566	4,566	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	8,927	0	0	0	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	300	0	2,085	0	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.12
190.16	19016	RENOVO	0	6,137	0	2,155	2,155	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	224	0	29,569	29,569	192.01
192.02	19202	UNUSED	0	0	0	0	0	192.02
192.03	19203	UNUSED	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0	0	0	192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0	0	0	192.05
194.00	07950	UNAVIE	0	7,554	0	0	39,374	194.00
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)	484,572	3,803,318	853,973	2,661,864	1,963,397	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.200128	11.502236	92.461347	2.055070	1.977489	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,480	138,743	68,118	241,584	117,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.134929	0.419595	7.375271	0.186513	0.117913	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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	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 SERVICES & SUPPLY	100			14.00
15.00	01500	PHARMACY	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	572,040,864	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0	16,478,959	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,128,269	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	55	0	95,708,909	50.00
53.00	05300	ANESTHESIOLOGY	0	0	739,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	38,560,020	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	30,578,110	56.01
57.00	05700	CT SCAN	0	0	39,054,642	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	9,769,610	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	60,903,713	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	10,815,089	65.00
65.01	06501	SLEEP LAB	0	0	4,099,080	65.01
66.00	06600	PHYSICAL THERAPY	0	0	11,300,871	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20,238,585	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45	0	14,582,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	84,245,097	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	5,470,202	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,940,314	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	22,041,462	88.02
90.00	09000	CLINIC	0	0	10,416,127	90.00
91.00	09100	EMERGENCY	0	0	79,453,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	8,515,801	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	572,040,864	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	UNUSED	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	0	0	190.02
190.03	19003	MEDWORKS PHARM	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	190.07
190.08	19008	RAMPART	0	0	0	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	190.09
190.10	19010	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.10
190.11	19011	MHP ADMIN BUILDING	0	0	0	190.11
190.12	19012	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.12
190.16	19016	RENOVO	0	0	0	190.16
190.17	19017	IMA	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	190.18
190.19	19019	MHCD	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	HOSPITALIST	0	0	0	192.01
192.02	19202	UNUSED	0	0	0	192.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 11:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
192.03	19203	UNUSED	0	0	0		192.03
192.04	19204	MAJ MAJOR PULMONOLOGY	0	0	0		192.04
192.05	19205	MAJ MHP CARDIOVASCULAR	0	0	0		192.05
194.00	07950	UNAVIE	0	0	0		194.00
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)	240,271	18,449,949	3,463,963		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,402.710000	184,499.490000	0.006055		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	130,027	199,733	116,678		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,300.270000	1,997.330000	0.000204		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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,225,418		15,225,418	0	15,225,418	30.00
31.00	03100	INTENSIVE CARE UNIT	4,015,640		4,015,640	0	4,015,640	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,599,070		12,599,070	0	12,599,070	50.00
53.00	05300	ANESTHESIOLOGY	579,964		579,964	427,350	1,007,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,567,407		8,567,407	0	8,567,407	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,823,064		5,823,064	5,392	5,828,456	56.01
57.00	05700	CT SCAN	1,683,723		1,683,723	0	1,683,723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,152,105		1,152,105	0	1,152,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,873,566		9,873,566	114,320	9,987,886	60.00
65.00	06500	RESPIRATORY THERAPY	3,273,570	0	3,273,570	0	3,273,570	65.00
65.01	06501	SLEEP LAB	1,114,753	0	1,114,753	0	1,114,753	65.01
66.00	06600	PHYSICAL THERAPY	4,870,019	0	4,870,019	0	4,870,019	66.00
69.00	06900	ELECTROCARDIOLOGY	3,785,632		3,785,632	0	3,785,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,269,205		4,269,205	0	4,269,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,960,053		18,960,053	0	18,960,053	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,155,883		6,155,883	0	6,155,883	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,442,041		2,442,041	0	2,442,041	88.01
88.02	08802	RURAL HEALTH CLINIC III	25,105,203		25,105,203	0	25,105,203	88.02
90.00	09000	CLINIC	4,152,345		4,152,345	0	4,152,345	90.00
91.00	09100	EMERGENCY	8,226,938		8,226,938	19,127	8,246,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,509,458		1,509,458		1,509,458	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,310,299		3,310,299	0	3,310,299	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	146,695,356	0	146,695,356	566,189	147,261,545	200.00
201.00		Less Observation Beds	1,509,458		1,509,458		1,509,458	201.00
202.00		Total (see instructions)	145,185,898	0	145,185,898	566,189	145,752,087	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	15,370,041		15,370,041			30.00
31.00	03100	INTENSIVE CARE UNIT	6,128,269		6,128,269			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,977,933	81,730,976	95,708,909	0.131639	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	739,319	739,319	0.784457	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,888,597	35,671,423	38,560,020	0.222184	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	174,960	30,403,150	30,578,110	0.190432	0.000000	56.01
57.00	05700	CT SCAN	6,077,073	32,977,569	39,054,642	0.043112	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	639,467	9,130,143	9,769,610	0.117927	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,755,986	51,147,727	60,903,713	0.162118	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,748,153	2,066,936	10,815,089	0.302685	0.000000	65.00
65.01	06501	SLEEP LAB	0	4,099,080	4,099,080	0.271952	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,237,216	10,063,655	11,300,871	0.430942	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,535,329	17,703,256	20,238,585	0.187050	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,025,998	11,557,001	14,582,999	0.292752	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,845,705	72,399,392	84,245,097	0.225058	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,470,202	5,470,202			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,940,314	2,940,314			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	22,041,462	22,041,462			88.02
90.00	09000	CLINIC	602,127	9,814,000	10,416,127	0.398646	0.000000	90.00
91.00	09100	EMERGENCY	11,057,196	68,396,490	79,453,686	0.103544	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,000	1,104,918	1,108,918	1.361199	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,201,340	7,314,461	8,515,801	0.388724	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	95,269,390	476,771,474	572,040,864			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	95,269,390	476,771,474	572,040,864			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		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	0.131639	50.00
53.00	05300	ANESTHESIOLOGY	1.362489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222184	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05601	ONCOLOGY	0.190609	56.01
57.00	05700	CT SCAN	0.043112	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117927	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.163995	60.00
65.00	06500	RESPIRATORY THERAPY	0.302685	65.00
65.01	06501	SLEEP LAB	0.271952	65.01
66.00	06600	PHYSICAL THERAPY	0.430942	66.00
69.00	06900	ELECTROCARDIOLOGY	0.187050	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.292752	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225058	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.398646	90.00
91.00	09100	EMERGENCY	0.103785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361199	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.388724	92.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 11:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,225,418		15,225,418	0	15,225,418	30.00
31.00	03100	INTENSIVE CARE UNIT	4,015,640		4,015,640	0	4,015,640	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,599,070		12,599,070	0	12,599,070	50.00
53.00	05300	ANESTHESIOLOGY	579,964		579,964	427,350	1,007,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,567,407		8,567,407	0	8,567,407	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	5,823,064		5,823,064	5,392	5,828,456	56.01
57.00	05700	CT SCAN	1,683,723		1,683,723	0	1,683,723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,152,105		1,152,105	0	1,152,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,873,566		9,873,566	114,320	9,987,886	60.00
65.00	06500	RESPIRATORY THERAPY	3,273,570	0	3,273,570	0	3,273,570	65.00
65.01	06501	SLEEP LAB	1,114,753	0	1,114,753	0	1,114,753	65.01
66.00	06600	PHYSICAL THERAPY	4,870,019	0	4,870,019	0	4,870,019	66.00
69.00	06900	ELECTROCARDIOLOGY	3,785,632		3,785,632	0	3,785,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,269,205		4,269,205	0	4,269,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,960,053		18,960,053	0	18,960,053	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,155,883		6,155,883	0	6,155,883	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,442,041		2,442,041	0	2,442,041	88.01
88.02	08802	RURAL HEALTH CLINIC III	25,105,203		25,105,203	0	25,105,203	88.02
90.00	09000	CLINIC	4,152,345		4,152,345	0	4,152,345	90.00
91.00	09100	EMERGENCY	8,226,938		8,226,938	19,127	8,246,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,509,458		1,509,458		1,509,458	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,310,299		3,310,299	0	3,310,299	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	146,695,356	0	146,695,356	566,189	147,261,545	200.00
201.00		Less Observation Beds	1,509,458		1,509,458		1,509,458	201.00
202.00		Total (see instructions)	145,185,898	0	145,185,898	566,189	145,752,087	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 11:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	15,370,041		15,370,041			30.00
31.00	03100	INTENSIVE CARE UNIT	6,128,269		6,128,269			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,977,933	81,730,976	95,708,909	0.131639	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	739,319	739,319	0.784457	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,888,597	35,671,423	38,560,020	0.222184	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	174,960	30,403,150	30,578,110	0.190432	0.000000	56.01
57.00	05700	CT SCAN	6,077,073	32,977,569	39,054,642	0.043112	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	639,467	9,130,143	9,769,610	0.117927	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,755,986	51,147,727	60,903,713	0.162118	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,748,153	2,066,936	10,815,089	0.302685	0.000000	65.00
65.01	06501	SLEEP LAB	0	4,099,080	4,099,080	0.271952	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,237,216	10,063,655	11,300,871	0.430942	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,535,329	17,703,256	20,238,585	0.187050	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,025,998	11,557,001	14,582,999	0.292752	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,845,705	72,399,392	84,245,097	0.225058	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,470,202	5,470,202	1.125348	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,940,314	2,940,314	0.830537	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	22,041,462	22,041,462	1.138999	0.000000	88.02
90.00	09000	CLINIC	602,127	9,814,000	10,416,127	0.398646	0.000000	90.00
91.00	09100	EMERGENCY	11,057,196	68,396,490	79,453,686	0.103544	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,000	1,104,918	1,108,918	1.361199	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,201,340	7,314,461	8,515,801	0.388724	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	95,269,390	476,771,474	572,040,864			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	95,269,390	476,771,474	572,040,864			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/28/2024 11:18 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05601	ONCOLOGY	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	06501	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/28/2024 11:18 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,207,405	0	1,207,405	8,261	146.16	30.00
31.00	INTENSIVE CARE UNIT	245,245		245,245	1,692	144.94	31.00
200.00	Total (lines 30 through 199)	1,452,650		1,452,650	9,953		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,311	337,776	30.00
31.00	INTENSIVE CARE UNIT	379	54,932	31.00
200.00	Total (lines 30 through 199)	2,690	392,708	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,307,251	95,708,909	0.013659	2,860,526	39,072	50.00
53.00	05300	ANESTHESIOLOGY	28,790	739,319	0.038941	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	472,595	38,560,020	0.012256	958,359	11,746	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	842,659	30,578,110	0.027558	44,442	1,225	56.01
57.00	05700	CT SCAN	76,094	39,054,642	0.001948	2,019,138	3,933	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69,550	9,769,610	0.007119	211,313	1,504	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	291,610	60,903,713	0.004788	2,930,721	14,032	60.00
65.00	06500	RESPIRATORY THERAPY	214,400	10,815,089	0.019824	2,816,997	55,844	65.00
65.01	06501	SLEEP LAB	122,299	4,099,080	0.029836	0	0	65.01
66.00	06600	PHYSICAL THERAPY	507,899	11,300,871	0.044943	446,814	20,081	66.00
69.00	06900	ELECTROCARDIOLOGY	178,223	20,238,585	0.008806	913,602	8,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	81,714	14,582,999	0.005603	987,168	5,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216,919	84,245,097	0.002575	3,198,063	8,235	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	339,217	5,470,202	0.062012	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	191,315	2,940,314	0.065066	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,152,371	22,041,462	0.052282	0	0	88.02
90.00	09000	CLINIC	334,827	10,416,127	0.032145	15,030	483	90.00
91.00	09100	EMERGENCY	639,596	79,453,686	0.008050	3,443,227	27,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	119,703	1,108,918	0.107946	3,839	414	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	311,089	8,515,801	0.036531	344,679	12,591	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,498,121	550,542,554		21,193,918	210,454	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/28/2024 11:18 am

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,261	0.00	2,311	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,692	0.00	379	31.00
200.00		Total (lines 30 through 199)		0	9,953		2,690	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 11:18 am

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		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 11:18 am

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		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	95,708,909	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	739,319	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,560,020	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	0	0	0	30,578,110	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	39,054,642	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,769,610	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	60,903,713	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,815,089	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	4,099,080	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,300,871	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,238,585	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,582,999	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,245,097	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,470,202	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,940,314	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	22,041,462	0.000000	88.02
90.00	09000	CLINIC	0	0	0	10,416,127	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	79,453,686	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,108,918	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	8,515,801	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	550,542,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

		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	2,860,526	0	12,143,855	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	958,359	0	5,624,842	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.000000	44,442	0	7,610,425	0	56.01
57.00	05700	CT SCAN	0.000000	2,019,138	0	5,489,115	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	211,313	0	1,609,157	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	2,930,721	0	3,408,732	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,816,997	0	466,941	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	633,072	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	446,814	0	38,297	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	913,602	0	3,832,990	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	987,168	0	2,393,654	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,198,063	0	21,518,412	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	15,030	0	2,618,183	0	90.00
91.00	09100	EMERGENCY	0.000000	3,443,227	0	7,460,737	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,839	0	577,096	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	344,679	0	1,578,150	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		21,193,918	0	77,003,658	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 11:18 am

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		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	0.131639	12,143,855	0	0	1,598,605	50.00
53.00	05300	ANESTHESIOLOGY	0.784457	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222184	5,624,842	0	0	1,249,750	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.190432	7,610,425	0	0	1,449,268	56.01
57.00	05700	CT SCAN	0.043112	5,489,115	0	0	236,647	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117927	1,609,157	0	0	189,763	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.162118	3,408,732	38,970	0	552,617	60.00
65.00	06500	RESPIRATORY THERAPY	0.302685	466,941	0	0	141,336	65.00
65.01	06501	SLEEP LAB	0.271952	633,072	1,332	0	172,165	65.01
66.00	06600	PHYSICAL THERAPY	0.430942	38,297	0	0	16,504	66.00
69.00	06900	ELECTROCARDIOLOGY	0.187050	3,832,990	0	0	716,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.292752	2,393,654	0	0	700,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225058	21,518,412	0	3,882	4,842,891	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.398646	2,618,183	0	0	1,043,728	90.00
91.00	09100	EMERGENCY	0.103544	7,460,737	0	0	772,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361199	577,096	0	0	785,542	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.388724	1,578,150	0	0	613,465	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		77,003,658	40,302	3,882	15,082,504	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		77,003,658	40,302	3,882	15,082,504	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/28/2024 11:18 am

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		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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	0	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	6,318	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	362	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	874	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,680	874	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,680	874	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

	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)	8,261	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,261	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)	7,442	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,311	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	15,225,418	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,225,418	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)	15,225,418	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,843.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,259,289	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)	4,259,289	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,015,640	1,692	2,373.31	379	899,484	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)	3,917,959	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)	9,076,732	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)	392,708	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	210,454	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	603,162	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,473,570	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)	819	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,843.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,509,458	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,207,405	15,225,418	0.079302	1,509,458	119,703	90.00
91.00	Nursing Program cost	0	15,225,418	0.000000	1,509,458	0	91.00
92.00	Allied health cost	0	15,225,418	0.000000	1,509,458	0	92.00
93.00	All other Medical Education	0	15,225,418	0.000000	1,509,458	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 11:18 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,261	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,261	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)	7,442	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	579	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	15,225,418	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,225,418	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)	15,225,418	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,843.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,067,126	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,067,126	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 11:18 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,015,640	1,692	2,373.31	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)	830,870	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,897,996	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)	819	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,843.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 11:18 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,509,458	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,207,405	15,225,418	0.079302	1,509,458	119,703	90.00
91.00	Nursing Program cost	0	15,225,418	0.000000	1,509,458	0	91.00
92.00	Allied health cost	0	15,225,418	0.000000	1,509,458	0	92.00
93.00	All other Medical Education	0	15,225,418	0.000000	1,509,458	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,675,384		30.00
31.00	03100	INTENSIVE CARE UNIT		1,520,193		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131639	2,860,526	376,557	50.00
53.00	05300	ANESTHESIOLOGY	1.362489	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222184	958,359	212,932	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.190609	44,442	8,471	56.01
57.00	05700	CT SCAN	0.043112	2,019,138	87,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117927	211,313	24,920	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.163995	2,930,721	480,624	60.00
65.00	06500	RESPIRATORY THERAPY	0.302685	2,816,997	852,663	65.00
65.01	06501	SLEEP LAB	0.271952	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.430942	446,814	192,551	66.00
69.00	06900	ELECTROCARDIOLOGY	0.187050	913,602	170,889	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.292752	987,168	288,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225058	3,198,063	719,750	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.398646	15,030	5,992	90.00
91.00	09100	EMERGENCY	0.103785	3,443,227	357,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361199	3,839	5,226	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.388724	344,679	133,985	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,193,918	3,917,959	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)		21,193,918		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 11:18 am
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		606,004		30.00
31.00	03100	INTENSIVE CARE UNIT		948,681		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131639	398,385	52,443	50.00
53.00	05300	ANESTHESIOLOGY	0.784457	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222184	160,647	35,693	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.190432	0	0	56.01
57.00	05700	CT SCAN	0.043112	262,067	11,298	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117927	16,722	1,972	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.162118	532,227	86,284	60.00
65.00	06500	RESPIRATORY THERAPY	0.302685	1,110,464	336,121	65.00
65.01	06501	SLEEP LAB	0.271952	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.430942	27,766	11,966	66.00
69.00	06900	ELECTROCARDIOLOGY	0.187050	87,942	16,450	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.292752	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225058	849,517	191,191	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.125348	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.830537	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.138999	0	0	88.02
90.00	09000	CLINIC	0.398646	0	0	90.00
91.00	09100	EMERGENCY	0.103544	570,880	59,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361199	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.388724	72,907	28,341	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,089,524	830,870	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)		4,089,524		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,818,930	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,455,155	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	30,949	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	43.75	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.96	30.00
31.00	Percentage of Medicaid patient days (see instructions)	28.19	31.00
32.00	Sum of lines 30 and 31	30.15	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/28/2024 11:18 am
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Line	Description		1.00	
34.00	Disproportionate share adjustment (see instructions)		188,223	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	934,613	887,601	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	699,039	223,113	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	922,152		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,415,409		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

Line	Description	Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,415,409	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	477,075	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	35,520	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,928,004	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,928,004	61.00
62.00	Deductibles billed to program beneficiaries	793,204	62.00
63.00	Coinsurance billed to program beneficiaries	6,000	63.00
64.00	Allowable bad debts (see instructions)	48,946	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	31,815	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,727	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,160,615	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-2,864	70.93
70.94	HRR adjustment amount (see instructions)	-27,809	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/28/2024 11:18 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	544,532	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2024	196,079	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,870,553	71.00
71.01	Sequestration adjustment (see instructions)		157,411	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		7,417,649	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		295,493	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		197,940	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,818,930	0	4,818,930		4,818,930	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,455,155	0		1,455,155	1,455,155	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	30,949	0		30,949	30,949	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	188,223	0	144,568	43,655	188,223	11.00
11.01	Uncompensated care payments	36.00	922,152	0	699,039	223,113	922,152	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,415,409	0	5,662,537	1,752,872	7,415,409	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,415,409	0	5,662,537	1,752,872	7,415,409	15.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2024 11:18 am
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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	477,075	0	362,529	114,546	477,075	16.00
17.00	Special add-on payments for new technologies	54.00	35,520	0	35,520	0	35,520	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,060,586	1,867,418	7,928,004	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	474,847	0	362,529	112,318	474,847	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,228	0	0	2,228	2,228	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	477,075	0	362,529	114,546	477,075	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.089848	0.105000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			544,532		544,532	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				196,079	196,079	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,818,930	4,818,930		4,818,930	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,455,155		1,455,155	1,455,155	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	30,949		30,949	30,949	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	188,223	144,568	43,655	188,223	11.00
11.01	Uncompensated care payments	36.00	922,152	699,039	223,113	922,152	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,415,409	5,662,537	1,752,872	7,415,409	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,415,409	5,662,537	1,752,872	7,415,409	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	477,075	362,529	114,546	477,075	16.00
17.00	Special add-on payments for new technologies	54.00	35,520	35,520	0	35,520	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,060,586	1,867,418	7,928,004	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2024 11:18 am
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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	474,847	362,529	112,318	474,847	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,228	0	2,228	2,228	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	477,075	362,529	114,546	477,075	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	544,532	544,532		544,532	28.00
29.00	Low volume adjustment on or after October 1	70.97	196,079		196,079	196,079	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-2,864	0	-2,864	-2,864	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-27,809	-18,932	-8,877	-27,809	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,554	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,082,504	2.00
3.00	OPPS or REH payments	12,417,722	3.00
4.00	Outlier payment (see instructions)	12,997	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,554	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	44,184	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)	44,184	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)	44,184	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	36,630	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)	7,554	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)	12,430,719	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	266	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,314,950	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)	10,123,057	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	10,123,057	30.00
31.00	Primary payer payments	2,511	31.00
32.00	Subtotal (line 30 minus line 31)	10,120,546	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)	169,973	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	110,482	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	130,117	36.00
37.00	Subtotal (see instructions)	10,231,028	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-96	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)	10,231,124	40.00
40.01	Sequestration adjustment (see instructions)	204,622	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	10,040,392	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)	-13,890	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

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/28/2024 11:18 am
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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		7,364,342		9,917,503	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	12/31/2023	53,307	12/31/2023	122,889	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)		53,307		122,889	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)		7,417,649		10,040,392	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		295,493		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		13,890	6.02
7.00	Total Medicare program liability (see instructions)		7,713,142		10,026,502	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: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	Hospital	PPS

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

Provider CCN: 15-0097

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

Worksheet E-3 Part VII Date/Time Prepared: 5/28/2024 11:18 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,897,996		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)	1,897,996	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)	1,897,996	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	4,089,524	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)	4,089,524	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)	4,089,524	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,191,528	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,897,996	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)	1,897,996	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,897,996	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	5,771	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)	1,892,225	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,892,225	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)	1,892,225	0	40.00
41.00	Interim payments	2,735,912	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-843,687	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/28/2024 11:18 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,858,906	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	54,983,633	0	0	0	4.00
5.00	Other receivable	6,440,737	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-39,213,340	0	0	0	6.00
7.00	Inventory	5,492,830	0	0	0	7.00
8.00	Prepaid expenses	3,182,842	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,745,608	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,900,662	0	0	0	12.00
13.00	Land improvements	13,006,660	0	0	0	13.00
14.00	Accumulated depreciation	-6,588,460	0	0	0	14.00
15.00	Buildings	150,526,009	0	0	0	15.00
16.00	Accumulated depreciation	-42,844,830	0	0	0	16.00
17.00	Leasehold improvements	264,162	0	0	0	17.00
18.00	Accumulated depreciation	-256,587	0	0	0	18.00
19.00	Fixed equipment	6,995,414	0	0	0	19.00
20.00	Accumulated depreciation	-3,586,772	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	67,469,790	0	0	0	23.00
24.00	Accumulated depreciation	-47,422,236	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)	140,463,812	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	810,968	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	413,322,986	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	414,133,954	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	589,343,374	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,881,048	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,223,063	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	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	89,057,631	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	108,161,742	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	85,608,531	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	85,608,531	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	193,770,273	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	395,573,101				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)	395,573,101	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	589,343,374	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/28/2024 11:18 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		345,050,082		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		50,523,016				2.00
3.00	Total (sum of line 1 and line 2)		395,573,098		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		395,573,101		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)		395,573,101		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	ROUNDING		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: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2024 11:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,176,762		15,176,762	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,176,762		15,176,762	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,459,967		6,459,967	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)	6,459,967		6,459,967	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,636,729		21,636,729	17.00
18.00	Ancillary services	73,115,514	478,890,369	552,005,883	18.00
19.00	Outpatient services	0	38,969	38,969	19.00
20.00	RURAL HEALTH CLINIC	0	5,470,202	5,470,202	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	94,752,243	484,399,540	579,151,783	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		186,799,675		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)		186,799,675		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0097	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/28/2024 11:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	579,151,783	1.00
2.00	Less contractual allowances and discounts on patients' accounts	387,551,793	2.00
3.00	Net patient revenues (line 1 minus line 2)	191,599,990	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	186,799,675	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,800,315	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	45,722,701	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	45,722,701	25.00
26.00	Total (line 5 plus line 25)	50,523,016	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)	50,523,016	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet L Parts I-III Date/Time Prepared: 5/28/2024 11:18 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	474,847	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,228	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	25.30	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	477,075	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8529 | Date/Time Prepared: 5/28/2024 11:18 am

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	271,384	942,753	1,214,137	83,665	1,297,802	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	120,507	0	120,507	0	120,507	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	62,045	0	62,045	74,811	136,856	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,075,960	0	1,075,960	0	1,075,960	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,529,896	942,753	2,472,649	158,476	2,631,125	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	338,918	338,918	0	338,918	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	338,918	338,918	0	338,918	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,529,896	1,281,671	2,811,567	158,476	2,970,043	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	73,590	73,590	0	73,590	29.00
30.00	Administrative Costs	196,087	142,919	339,006	0	339,006	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	196,087	216,509	412,596	0	412,596	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,725,983	1,498,180	3,224,163	158,476	3,382,639	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2023 To 12/31/2023	Worksheet M-1 Date/Time Prepared: 5/28/2024 11:18 am
		RHC I	

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	494,647	1,792,449	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	120,507	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	136,856	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	1,075,960	9.00
10.00	Subtotal (sum of lines 1 through 9)	494,647	3,125,772	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	338,918	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	338,918	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	494,647	3,464,690	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	73,590	29.00
30.00	Administrative Costs	333,261	672,267	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	333,261	745,857	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	827,908	4,210,547	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8531 | Date/Time Prepared: 5/28/2024 11:18 am

RHC II

		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	588,716	588,716	0	588,716	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	131,345	0	131,345	0	131,345	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	74,811	0	74,811	-74,811	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	285,859	0	285,859	0	285,859	9.00
10.00	Subtotal (sum of lines 1 through 9)	492,015	588,716	1,080,731	-74,811	1,005,920	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	285,762	285,762	0	285,762	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	285,762	285,762	0	285,762	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	492,015	874,478	1,366,493	-74,811	1,291,682	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	1,245,326	1,245,326	0	1,245,326	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,245,326	1,245,326	0	1,245,326	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,166	8,166	0	8,166	29.00
30.00	Administrative Costs	192,034	69,360	261,394	0	261,394	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	192,034	77,526	269,560	0	269,560	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	684,049	2,197,330	2,881,379	-74,811	2,806,568	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 11:18 am

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-155,123	433,593	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	131,345	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	285,859	9.00
10.00	Subtotal (sum of lines 1 through 9)	-155,123	850,797	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	285,762	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	285,762	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-155,123	1,136,559	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	-1,245,326	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-1,245,326	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	8,166	29.00
30.00	Administrative Costs	171,405	432,799	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	171,405	440,965	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,229,044	1,577,524	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 11:18 am

RHC III

		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	743,401	4,423,266	5,166,667	0	5,166,667	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	215,260	0	215,260	0	215,260	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	3,390	3,390	0	3,390	6.00
7.00	Clinical Social Worker	201,124	0	201,124	0	201,124	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	4,024,235	0	4,024,235	0	4,024,235	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,184,020	4,426,656	9,610,676	0	9,610,676	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	390,478	1,421,449	1,811,927	0	1,811,927	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)	390,478	1,421,449	1,811,927	0	1,811,927	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,574,498	5,848,105	11,422,603	0	11,422,603	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	472,556	472,556	0	472,556	29.00
30.00	Administrative Costs	2,093,826	760,966	2,854,792	0	2,854,792	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,093,826	1,233,522	3,327,348	0	3,327,348	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,668,324	7,081,627	14,749,951	0	14,749,951	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8532 | Date/Time Prepared: 5/28/2024 11:18 am

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-888,940	4,277,727	1.00
2.00	Physician Assistant	165,561	165,561	2.00
3.00	Nurse Practitioner	2,395,330	2,610,590	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	3,390	6.00
7.00	Clinical Social Worker	0	201,124	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	4,024,235	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,671,951	11,282,627	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	1,811,927	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	1,811,927	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,671,951	13,094,554	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	472,556	29.00
30.00	Administrative Costs	1,021,337	3,876,129	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,021,337	4,348,685	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,693,288	17,443,239	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2

Component CCN: 15-8529 | Date/Time Prepared: 5/28/2024 11:18 am

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.71	9,841	1	5		1.00
2.00	Physician Assistant	1.00	2,732	1	1		2.00
3.00	Nurse Practitioner	2.86	8,692	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.57	21,265		9	21,265	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	0.71	1,983			1,983	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.28	23,248			23,248	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	3,464,690	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	3,464,690	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)	745,857	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,945,336	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,691,193	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,691,193	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,691,193	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	6,155,883	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 5/28/2024 11:18 am
		RHC II	

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.60	5,562	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.93	2,825	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.53	8,387		3	8,387	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.53	8,387			8,387	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,136,559	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,136,559	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)	440,965	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	864,517	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,305,482	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,305,482	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,305,482	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,442,041	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2
Component CCN: 15-8532 | Date/Time Prepared: 5/28/2024 11:18 am

RHC III

		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	10.89	33,731	1	11		1.00
2.00	Physician Assistant	1.00	2,918	1	1		2.00
3.00	Nurse Practitioner	16.91	30,108	1	17		3.00
4.00	Subtotal (sum of lines 1 through 3)	28.80	66,757		29	66,757	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	2.21	1,438			1,438	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	31.01	68,195			68,195	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)	13,094,554	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)	13,094,554	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)	4,348,685	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	7,661,964	15.00
16.00	Total overhead (sum of lines 14 and 15)	12,010,649	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	12,010,649	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	12,010,649	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	25,105,203	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC I	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		6,155,883	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		173,623	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		5,982,260	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		23,248	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)		23,248	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		257.32	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	263.87	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	257.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	55	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	14,153	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	14,153	16.00
16.01	Total program charges (see instructions)(from contractor's records)		9,695	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		10,796	16.04
16.05	Total program cost (see instructions)	0	10,796	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		658	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,807	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		10,796	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		10,796	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)		10,796	26.00
26.01	Sequestration adjustment (see instructions)		216	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		10,299	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)		281	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: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC II	

			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)		2,442,041	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		3,528	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,438,513	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,387	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,387	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		290.75	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	475.67	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	290.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	204	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	59,313	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	59,313	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,857	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,864	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,636	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.)		29,530	16.04
16.05	Total program cost (see instructions)	0	49,166	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,764	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,646	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		49,166	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		49,166	22.00
23.00	Allowable bad debts (see instructions)		100	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		65	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		100	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		49,231	26.00
26.01	Sequestration adjustment (see instructions)		985	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		69,799	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)		-21,553	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: 15-0097 Component CCN: 15-8532	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC III	

			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)		25,105,203	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		281,729	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		24,823,474	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		68,195	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)		68,195	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		364.01	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	365.43	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	364.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	13,659	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	4,972,013	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	113	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	41,133	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	41,133	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	5,013,146	16.00
16.01	Total program charges (see instructions)(from contractor's records)		3,780,656	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		624,364	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		827,906	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.)		3,168,233	16.04
16.05	Total program cost (see instructions)	0	3,996,139	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		224,949	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		585,842	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		3,996,139	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		60,081	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		4,056,220	22.00
23.00	Allowable bad debts (see instructions)		19,802	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		12,871	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,690	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)		4,069,091	26.00
26.01	Sequestration adjustment (see instructions)		81,382	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		3,636,889	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)		350,820	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: 15-0097 Component CCN: 15-8529	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC I	

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,125,772	3,125,772	3,125,772	3,125,772	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001511	0.008566	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,723	26,775	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,386	48,836	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	22,109	75,611	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,464,690	3,464,690	3,464,690	3,464,690	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,691,193	2,691,193	2,691,193	2,691,193	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006381	0.021823	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,173	58,730	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39,282	134,341	0	0	10.00
11.00	Total number of injections/infusions (from your records)	175	996	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	224.47	134.88	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		173,623	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC II	

		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)	850,797	850,797	850,797	850,797	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000310	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	264	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,378	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	1,642	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,136,559	1,136,559	1,136,559	1,136,559	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,305,482	1,305,482	1,305,482	1,305,482	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001445	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	1,886	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	3,528	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	28	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	126.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		3,528	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/28/2024 11:18 am
	Title XVIII	RHC III	

		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)	11,282,627	11,282,627	11,282,627	11,282,627	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000098	0.001930	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,106	21,775	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11,525	112,540	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,631	134,315	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	13,094,554	13,094,554	13,094,554	13,094,554	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	12,010,649	12,010,649	12,010,649	12,010,649	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000965	0.010257	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,590	123,193	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	24,221	257,508	0	0	10.00
11.00	Total number of injections/infusions (from your records)	116	2,989	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	208.80	86.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	34	615	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)	7,099	52,982	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)		281,729	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)		60,081	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 11:18 am
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		10,299	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)		10,299	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		281	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		10,580	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: 15-0097 Component CCN: 15-8531	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 11:18 am
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		69,799	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)		69,799	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		21,553	6.02
7.00	Total Medicare program liability (see instructions)		48,246	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 11:18 am
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		3,636,889	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)		3,636,889	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		350,820	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,987,709	7.00

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