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: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 9:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 9:40 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 PUTNAM COUNTY HOSPITAL (15-1333) 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	Dennis Weatherford		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	Dennis Weatherford			2
3	Signatory Title	CEO			3
4	Date	05/30/2024 09:40:10 AM			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	333,216	-119,823	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	31,276	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		10,973		0	10.00
10.01	RURAL HEALTH CLINIC II	0		30,293		0	10.01
10.02	RURAL HEALTH CLINIC III	0		19,167		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		15,412		0	10.03
200.00	TOTAL	0	364,492	-43,978	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 9:40 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:			1.00
2.00	City: GREENCASTLE	State: IN	Zip Code: 46135-	County: PUTNAM	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	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	PPIM	158515	26900		02/23/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	FMC	158513	26900		02/25/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NPFH	158514	26900		03/17/2015	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	FMG	158572	26900		09/22/2023	N	O	N	15.03
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)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 9:40 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 9:40 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	115,120	0	0	118.01

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 9:40 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 9:40 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/09/2024	Y	04/09/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

		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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	ROGERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	DANR@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 9:40 am

		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.	PARTNER		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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 9:40 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	19	6,935	19,320.00	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)		19	6,935	19,320.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	2,040.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	21,360.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 9:40 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	414	9	805			1.00
2.00	HMO and other (see instructions)	212	47				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	53	0	159			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)	467	9	964			7.00
8.00	INTENSIVE CARE UNIT	33	1	85			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)	500	10	1,049	0.00	297.82	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	590	3,669	9,656	0.00	17.04	26.00
26.01	RURAL HEALTH CLINIC II	1,268	2,875	10,704	0.00	18.32	26.01
26.02	RURAL HEALTH CLINIC III	876	2,805	8,709	0.00	17.63	26.02
26.03	RURAL HEALTH CLINIC IV	408	592	2,819	0.00	4.34	26.03
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	355.15	27.00
28.00	Observation Bed Days		24	1,130			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			3			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 9:40 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	151	5	346	1.00
2.00	HMO and other (see instructions)			65	25		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	151	5	346	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 9:40 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1542 S. BLOOMINGTON STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GREENCASTLE	IN	46135	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: 15-1333 Component CCN: 15-8515	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/30/2024 9:40 am
		RHC I	Cost

			County		
			4.00		
2.00	City, State, ZIP Code, County		PUTNAM		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-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 9:40 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	51 E. MARKET STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CLOVERDALE	IN	46120	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	17:30	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: 15-1333 Component CCN: 15-8513	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/30/2024 9:40 am
		RHC II	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 9:40 am

RHC III | Cost

Line	Description	1.00	
	Clinic Address and Identification		
1.00	Street	209 E. PAT RADY WAY	1.00

Line	Description	City 1.00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County	BAINBRIDGE	IN	46105	2.00

Line	Description	1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

Line	Description	Grant Award 1.00	Date 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

Line	Description	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

Line	Description	Sunday from 1.00	Sunday to 2.00	Monday from 3.00	Monday to 4.00	Tuesday from 5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	07:00	11.00

Line	Description	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

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

Line	Description	Y/N 1.00	V 2.00	XVIII 3.00	XIX 4.00	Total Visits 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: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8
Component CCN: 15-8514		Date/Time Prepared: 5/30/2024 9:40 am
	RHC III	Cost

		County	
		4.00	
2.00	City, State, ZIP Code, County	PUTNAM	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-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333 | Component CCN: 15-8572 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 9:40 am

RHC IV | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	309 MEDIC WAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GREENCASTLE	IN	46135	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1333 Component CCN: 15-8572	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/30/2024 9:40 am
		RHC IV	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 9:40 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)	0.404391	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,278,819	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,092,566	5.00
6.00	Medicaid charges	25,333,135	6.00
7.00	Medicaid cost (line 1 times line 6)	10,244,492	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,873,107	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)	2,873,107	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)	430,550	0	430,550	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	174,111	0	174,111	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)	174,111	0	174,111	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	4,654,681	26.00
27.00	Medicare reimbursable bad debts (see instructions)	360,011	27.00
27.01	Medicare allowable bad debts (see instructions)	553,863	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,100,818	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,852,186	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,026,297	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,899,404	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 9:40 am

				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)				1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit				25.00
25.01	Charges for insured patients' liability (see instructions)				25.01
26.00	Bad debt amount (see instructions)				26.00
27.00	Medicare reimbursable bad debts (see instructions)				27.00
27.01	Medicare allowable bad debts (see instructions)				27.01
28.00	Non-Medicare bad debt amount (see instructions)				28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,403,469	2,403,469	-695,143	1,708,326	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		423,877	423,877	817,914	1,241,791	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174,145	5,376,138	5,550,283	0	5,550,283	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,545,283	7,450,141	10,995,424	-122,771	10,872,653	5.00
7.00	00700	OPERATION OF PLANT	372,104	1,196,517	1,568,621	0	1,568,621	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,323	234,377	267,700	0	267,700	8.00
9.00	00900	HOUSEKEEPING	510,528	177,460	687,988	0	687,988	9.00
10.00	01000	DIETARY	507,736	766,451	1,274,187	-891,968	382,219	10.00
11.00	01100	CAFETERIA	0	0	0	891,968	891,968	11.00
13.00	01300	NURSING ADMINISTRATION	140,480	59,018	199,498	0	199,498	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	23,233	23,233	0	23,233	14.00
15.00	01500	PHARMACY	366,107	417,597	783,704	0	783,704	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	300,871	219,687	520,558	0	520,558	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	117,436	10,206	127,642	0	127,642	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,216,360	472,988	2,689,348	-8	2,689,340	30.00
31.00	03100	INTENSIVE CARE UNIT	302,328	630,028	932,356	-24,580	907,776	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	765,388	929,816	1,695,204	-240,364	1,454,840	50.00
51.00	05100	RECOVERY ROOM	54,302	25,449	79,751	0	79,751	51.00
53.00	05300	ANESTHESIOLOGY	788,674	84,827	873,501	0	873,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,274,599	480,578	1,755,177	0	1,755,177	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	241,335	241,335	0	241,335	54.01
54.02	03480	ONCOLOGY	431,587	3,982,890	4,414,477	0	4,414,477	54.02
57.00	05700	CT SCAN	83,041	182,288	265,329	0	265,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	82,392	127,596	209,988	0	209,988	58.00
60.00	06000	LABORATORY	962,994	2,106,953	3,069,947	0	3,069,947	60.00
65.00	06500	RESPIRATORY THERAPY	495,553	130,575	626,128	0	626,128	65.00
66.00	06600	PHYSICAL THERAPY	0	410,389	410,389	0	410,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,450	113,450	0	113,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,825	47,825	0	47,825	68.00
69.00	06900	ELECTROCARDIOLOGY	77,141	45,913	123,054	0	123,054	69.00
69.01	06901	CARDIAC REHAB	268,962	31,768	300,730	0	300,730	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	264,952	264,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	683,967	683,967	0	683,967	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,427,581	372,673	1,800,254	-31,936	1,768,318	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,556,142	380,403	1,936,545	4,777	1,941,322	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,488,907	429,688	1,918,595	27,159	1,945,754	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	446,441	446,441	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	132,328	23,833	156,161	0	156,161	90.01
91.00	09100	EMERGENCY	4,263,243	1,305,507	5,568,750	0	5,568,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,739,535	31,998,910	54,738,445	446,441	55,184,886	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,688,288	1,371,580	7,059,868	-446,441	6,613,427	192.00
192.01	19201	JOHNSON/NICHOLS WIC	294,084	106,218	400,302	0	400,302	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	28,721,907	33,476,708	62,198,615	0	62,198,615	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 9:40 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	-777,682	930,644	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,241,791	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,550,283	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,394,194	7,478,459	5.00
7.00	00700	OPERATION OF PLANT	-9,361	1,559,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	267,700	8.00
9.00	00900	HOUSEKEEPING	0	687,988	9.00
10.00	01000	DIETARY	0	382,219	10.00
11.00	01100	CAFETERIA	-67,691	824,277	11.00
13.00	01300	NURSING ADMINISTRATION	0	199,498	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	23,233	14.00
15.00	01500	PHARMACY	-27,915	755,789	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-48	520,510	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	127,642	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,137,748	1,551,592	30.00
31.00	03100	INTENSIVE CARE UNIT	0	907,776	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,454,840	50.00
51.00	05100	RECOVERY ROOM	0	79,751	51.00
53.00	05300	ANESTHESIOLOGY	-661,303	212,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,755,177	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	241,335	54.01
54.02	03480	ONCOLOGY	-11,490	4,402,987	54.02
57.00	05700	CT SCAN	0	265,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	209,988	58.00
60.00	06000	LABORATORY	0	3,069,947	60.00
65.00	06500	RESPIRATORY THERAPY	0	626,128	65.00
66.00	06600	PHYSICAL THERAPY	0	410,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,825	68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,054	69.00
69.01	06901	CARDIAC REHAB	-1,786	298,944	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	264,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	683,967	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-16,019	1,752,299	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,941,322	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,945,754	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	446,441	88.03
90.00	09000	CLINIC	0	0	90.00
90.01	09001	RHEUMATOLOGY	-90,077	66,084	90.01
91.00	09100	EMERGENCY	-2,391,801	3,176,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,587,115	46,597,771	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,613,427	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	400,302	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,587,115	53,611,500	200.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 9:40 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Cafeteria				
1.00	CAFETERIA	11.00	355,430	536,538	1.00
	TOTALS		355,430	536,538	
	B - Insurance				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		118,856	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		3,915	2.00
			0	122,771	
	C - Implants				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	264,952	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	264,952	
	D - Depreciation				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	137,983	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	951,982	2.00
	TOTALS		0	1,089,965	
	E - BHC Dept. 980				
1.00	RURAL HEALTH CLINIC II	88.01	3,374	584	1.00
2.00	RURAL HEALTH CLINIC III	88.02	19,181	3,318	2.00
			22,555	3,902	
	F - BHC Dept. 982				
1.00	RURAL HEALTH CLINIC II	88.01	648	117	1.00
2.00	RURAL HEALTH CLINIC III	88.02	3,684	667	2.00
			4,332	784	
	G - BHC DEPT. 987				
1.00	RURAL HEALTH CLINIC II	88.01	47	7	1.00
2.00	RURAL HEALTH CLINIC III	88.02	268	41	2.00
			315	48	
	H - FMG RHC				
1.00	RURAL HEALTH CLINIC IV	88.03	344,141	102,300	1.00
			344,141	102,300	
500.00	Grand Total: Increases		726,773	2,121,260	500.00

	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	355,430	536,538	0		1.00
	TOTALS		355,430	536,538			
	B - Insurance						
1.00	ADMINISTRATIVE & GENERAL	5.00		122,771	12		1.00
2.00					12		2.00
			0	122,771			
	C - Implants						
1.00	ADULTS & PEDIATRICS	30.00	0	8	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	24,580	0		2.00
3.00	OPERATING ROOM	50.00	0	240,364	0		3.00
	TOTALS		0	264,952			
	D - Depreciation						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	951,982	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	137,983	9		2.00
	TOTALS		0	1,089,965			
	E - BHC Dept. 980						
1.00	RURAL HEALTH CLINIC	88.00	22,555	3,902			1.00
2.00							2.00
			22,555	3,902			
	F - BHC Dept. 982						
1.00	RURAL HEALTH CLINIC	88.00	4,332	784			1.00
2.00							2.00
			4,332	784			
	G - BHC DEPT. 987						
1.00	RURAL HEALTH CLINIC	88.00	315	48			1.00
2.00							2.00
			315	48			
	H - FMG RHC						
1.00	PHYSICIANS PRIVATE OFFICES	192.00	344,141	102,300			1.00
			344,141	102,300			
500.00	Grand Total: Decreases		726,773	2,121,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 9:40 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	260,501	0	0	0	0	1.00
2.00	Land Improvements	391,896	71,900	0	71,900	0	2.00
3.00	Buildings and Fixtures	35,762,484	175,560	0	175,560	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,863,244	0	0	0	1,687,865	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	63,278,125	247,460	0	247,460	1,687,865	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	63,278,125	247,460	0	247,460	1,687,865	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	260,501	0	1.00
2.00	Land Improvements	463,796	0	2.00
3.00	Buildings and Fixtures	35,938,044	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	25,175,379	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,837,720	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	61,837,720	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2024 9:40 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,649,026	565,749	182,370	0	6,324	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	371,776	52,101	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,020,802	617,850	182,370	0	6,324	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,403,469	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	423,877	2.00
3.00	Total (sum of lines 1-2)	0	2,827,346	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2024 9:40 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,662,341	0	36,662,341	0.592880	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,175,379	0	25,175,379	0.407120	0	2.00
3.00	Total (sum of lines 1-2)	61,837,720	0	61,837,720	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	835,027	-29,563	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,185,775	52,101	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,020,802	22,538	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	118,856	6,324	0	930,644	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,915	0	0	1,241,791	2.00
3.00	Total (sum of lines 1-2)	0	122,771	6,324	0	2,172,435	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 9:40 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-14,095	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,361	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,882,962			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,691	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-48	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Rent Income	B	-29,563	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 9:40 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Cardiac Rehab Other Misc. Income	B	-117	CARDIAC REHAB	69.01	0	33.01
33.02	Pharmacy Rebates	B	-26,900	PHARMACY	15.00	0	33.02
33.03	Pharmacy Misc. Income	B	-1,015	PHARMACY	15.00	0	33.03
33.04	Silver Recovery	B	-177	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CBO Misc. Income	B	-8,945	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	Other Non-Operating Revenue	B	-974	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	Admin Other Misc. Income	B	-236	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.09	Advertising	A	-11,490	ONCOLOGY	54.02	0	33.09
33.10	Advertising	A	-1,669	CARDIAC REHAB	69.01	0	33.10
33.11	Advertising	A	-1,874	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	Intercompany Rent	A	-565,749	CAP REL COSTS-BLDG & FIXT	1.00	10	33.12
33.13	Community Relations	A	-57,556	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	Lobbying	A	-1,740	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	Physician Recruitment	A	-14,000	ADULTS & PEDIATRICS	30.00	0	33.15
33.16	Physician Recruitment	A	-15,000	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	HAF Expense	A	-3,310,471	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	Non-Allowable CRNA	A	-383,967	ANESTHESIOLOGY	53.00	0	33.18
33.19	Non-allowable Interest Expense	A	-31,636	CAP REL COSTS-BLDG & FIXT	1.00	11	33.19
33.20	Interest Expense	A	-150,734	CAP REL COSTS-BLDG & FIXT	1.00	11	33.20
33.21	BHC DEPT. 985 ADJUSTMENT	A	855	RURAL HEALTH CLINIC	88.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,587,115				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2024 9:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,123,748	1,123,748	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	362,566	277,336	85,230	0	0	2.00
3.00	90.01	RHEUMATOLOGY	90,077	90,077	0	0	0	3.00
4.00	91.00	EMERGENCY	2,999,361	2,391,801	607,560	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,575,752	3,882,962	692,790		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	90.01	RHEUMATOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,123,748		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	277,336		2.00
3.00	90.01	RHEUMATOLOGY	0	0	0	90,077		3.00
4.00	91.00	EMERGENCY	0	0	0	2,391,801		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,882,962		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2024 9:40 am
		Physical Therapy	Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	287	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	10	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	9.57	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,874.60	1,817.91	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	97.62	73.22	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	48.81	48.81	36.61			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	280,618	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	133,107	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	413,725	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	413,725	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	413,725	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	14,008	24.00
25.00	Assistants (line 4 times column 3, line 11)	366	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	14,374	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,842	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	17,216	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	17,216	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2024 9:40 am

Physical Therapy | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

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

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	413,725	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	17,216	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	430,941	63.00
64.00	Total cost of outside supplier services (from your records)	361,500	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,374	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,842	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	17,216	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,842	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,842	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2024 9:40 am
		Occupational Therapy	Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	253	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	9.57	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,680.87	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.54	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.27	46.27	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	155,548	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	155,548	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	155,548	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	155,548	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,706	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,706	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,421	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,127	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	14,127	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2024 9:40 am

Occupational Therapy | Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.54	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	155,548	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,127	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	169,675	63.00
64.00	Total cost of outside supplier services (from your records)	113,450	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,706	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,421	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,127	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,421	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,421	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2024 9:40 am

Speech Pathology | Cost

Line	Description	1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	163	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	9.57	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

Line	Description	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	Total hours worked	0.00	759.44	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	88.95	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	44.48	44.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

Line	Description	1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	67,552	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	67,552	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	67,552	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	88.95	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	69,381	22.00
23.00	Total salary equivalency (see instructions)	69,381	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	7,250	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,250	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,560	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,810	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,810	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2024 9:40 am

Speech Pathology | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	88.95	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	69,381	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,810	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	78,191	63.00
64.00	Total cost of outside supplier services (from your records)	47,825	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,250	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,560	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,810	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,560	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,560	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	930,644	930,644				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,241,791		1,241,791			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,550,283	1,265	1,688	5,553,236		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,478,459	120,938	161,372	689,643	8,450,412	5.00
7.00	00700	OPERATION OF PLANT	1,559,260	72,945	97,332	72,383	1,801,920	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	267,700	5,589	7,457	6,482	287,228	8.00
9.00	00900	HOUSEKEEPING	687,988	2,331	3,111	99,310	792,740	9.00
10.00	01000	DIETARY	382,219	28,019	37,386	29,627	477,251	10.00
11.00	01100	CAFETERIA	824,277	13,261	17,695	69,140	924,373	11.00
13.00	01300	NURSING ADMINISTRATION	199,498	5,498	7,336	27,327	239,659	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	23,233	0	0	0	23,233	14.00
15.00	01500	PHARMACY	755,789	7,408	9,884	71,217	844,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520,510	32,673	43,597	58,527	655,307	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	127,642	2,753	3,674	22,844	156,913	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,551,592	50,854	67,856	431,135	2,101,437	30.00
31.00	03100	INTENSIVE CARE UNIT	907,776	23,488	31,341	58,810	1,021,415	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,454,840	67,637	90,250	148,886	1,761,613	50.00
51.00	05100	RECOVERY ROOM	79,751	18,974	25,318	10,563	134,606	51.00
53.00	05300	ANESTHESIOLOGY	212,198	0	0	153,416	365,614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,177	25,059	33,437	247,940	2,061,613	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	241,335	1,157	1,544	0	244,036	54.01
54.02	03480	ONCOLOGY	4,402,987	40,155	53,581	83,954	4,580,677	54.02
57.00	05700	CT SCAN	265,329	1,984	2,648	16,153	286,114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	209,988	8,929	11,914	16,027	246,858	58.00
60.00	06000	LABORATORY	3,069,947	20,752	27,689	187,325	3,305,713	60.00
65.00	06500	RESPIRATORY THERAPY	626,128	5,787	7,722	96,397	736,034	65.00
66.00	06600	PHYSICAL THERAPY	410,389	14,088	18,798	0	443,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,450	0	0	0	113,450	67.00
68.00	06800	SPEECH PATHOLOGY	47,825	0	0	0	47,825	68.00
69.00	06900	ELECTROCARDIOLOGY	123,054	827	1,103	15,006	139,990	69.00
69.01	06901	CARDIAC REHAB	298,944	25,001	33,360	52,320	409,625	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	264,952	0	0	0	264,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	683,967	0	0	0	683,967	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,752,299	44,942	59,968	272,407	2,129,616	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,941,322	53,739	71,706	303,498	2,370,265	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,945,754	53,739	71,706	294,128	2,365,327	88.02
88.03	08803	RURAL HEALTH CLINIC IV	446,441	10,417	13,900	66,944	537,702	88.03
90.00	09000	CLINIC	0	1,339	1,787	0	3,126	90.00
90.01	09001	RHEUMATOLOGY	66,084	3,894	5,196	25,741	100,915	90.01
91.00	09100	EMERGENCY	3,176,949	48,001	64,050	829,303	4,118,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,597,771	813,443	1,085,406	4,456,453	45,227,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	3,944	5,262	0	9,206	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,613,427	107,528	143,478	1,039,577	7,904,010	192.00
192.01	19201	JOHNSON/NICHOLS WIC	400,302	0	0	57,206	457,508	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	5,729	7,645	0	13,374	194.01
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)	53,611,500	930,644	1,241,791	5,553,236	53,611,500	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,450,412					5.00
7.00	00700	OPERATION OF PLANT	337,170	2,139,090				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,745	16,254	357,227			8.00
9.00	00900	HOUSEKEEPING	148,335	6,781	2,005	949,861		9.00
10.00	01000	DIETARY	89,302	81,488	1,480	45,984	695,505	10.00
11.00	01100	CAFETERIA	172,966	38,568	0	21,764	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,844	15,990	0	9,023	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	4,347	0	0	0	0	14.00
15.00	01500	PHARMACY	157,983	21,544	0	12,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,619	95,026	0	53,623	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	29,361	8,007	0	4,518	0	17.01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	393,215	147,901	77,712	83,461	629,080	30.00
31.00	03100	INTENSIVE CARE UNIT	191,124	68,312	60,009	38,549	66,425	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	329,628	196,712	50,710	111,005	0	50.00
51.00	05100	RECOVERY ROOM	25,187	55,183	5,494	31,140	0	51.00
53.00	05300	ANESTHESIOLOGY	68,413	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385,763	72,880	26,723	41,127	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	45,663	3,366	0	1,900	0	54.01
54.02	03480	ONCOLOGY	857,123	116,786	11,483	65,903	0	54.02
57.00	05700	CT SCAN	53,537	5,771	0	3,256	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	46,191	25,969	0	14,654	0	58.00
60.00	06000	LABORATORY	618,555	60,353	0	34,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	137,724	16,831	0	9,498	0	65.00
66.00	06600	PHYSICAL THERAPY	82,944	40,973	9,865	23,121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,228	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,949	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,195	2,404	0	1,357	0	69.00
69.01	06901	CARDIAC REHAB	76,648	72,712	0	41,032	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,577	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,982	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	398,487	130,709	7,996	73,759	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	443,517	156,292	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	442,593	156,292	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	100,613	30,297	0	0	0	88.03
90.00	09000	CLINIC	585	3,895	0	2,198	0	90.00
90.01	09001	RHEUMATOLOGY	18,883	11,325	0	6,391	0	90.01
91.00	09100	EMERGENCY	770,605	139,605	86,981	78,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,881,601	1,798,226	340,458	808,258	695,505	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,723	11,469	0	6,472	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,478,977	312,732	16,769	125,728	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	85,608	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	2,503	16,663	0	9,403	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,450,412	2,139,090	357,227	949,861	695,505	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	1,157,671					11.00
13.00	01300	NURSING ADMINISTRATION	14,248	323,764				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	27,580			14.00
15.00	01500	PHARMACY	40,321	0	209	1,076,513		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,163	0	0	0	978,738	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	11,072	0	0	0	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153,038	126,337	693	0	290,801	30.00
31.00	03100	INTENSIVE CARE UNIT	29,107	24,029	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,385	0	5,577	0	533,562	50.00
51.00	05100	RECOVERY ROOM	6,869	0	200	0	0	51.00
53.00	05300	ANESTHESIOLOGY	24,676	0	199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,981	0	443	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	11	0	0	54.01
54.02	03480	ONCOLOGY	55,533	0	214	0	0	54.02
57.00	05700	CT SCAN	11,293	0	298	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,638	0	10	0	0	58.00
60.00	06000	LABORATORY	143,337	0	12,742	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	55,616	0	677	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	434	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,678	0	106	0	0	69.00
69.01	06901	CARDIAC REHAB	26,477	0	32	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,483	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,076,513	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	161	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	233	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	292	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	98	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	11,348	0	6	0	0	90.01
91.00	09100	EMERGENCY	210,042	173,398	1,257	0	154,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,119,822	323,764	26,375	1,076,513	978,738	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,188	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	37,849	0	17	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,157,671	323,764	27,580	1,076,513	978,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	17.01	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
17.01	01701	UTILIZATION REVIEW	0	209,871				17.01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	189,827	4,193,502	0	4,193,502	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,044	1,519,014	0	1,519,014	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	3,083,192	0	3,083,192	50.00
51.00	05100	RECOVERY ROOM	0	0	258,679	0	258,679	51.00
53.00	05300	ANESTHESIOLOGY	0	0	458,902	0	458,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,750,530	0	2,750,530	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	294,976	0	294,976	54.01
54.02	03480	ONCOLOGY	0	0	5,687,719	0	5,687,719	54.02
57.00	05700	CT SCAN	0	0	360,269	0	360,269	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	343,320	0	343,320	58.00
60.00	06000	LABORATORY	0	0	4,174,757	0	4,174,757	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	956,380	0	956,380	65.00
66.00	06600	PHYSICAL THERAPY	0	0	600,612	0	600,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	134,678	0	134,678	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	56,774	0	56,774	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	178,730	0	178,730	69.00
69.01	06901	CARDIAC REHAB	0	0	626,526	0	626,526	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	317,012	0	317,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,888,462	0	1,888,462	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	2,740,728	0	2,740,728	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,970,307	0	2,970,307	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,964,504	0	2,964,504	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	668,710	0	668,710	88.03
90.00	09000	CLINIC	0	0	9,804	0	9,804	90.00
90.01	09001	RHEUMATOLOGY	0	0	148,868	0	148,868	90.01
91.00	09100	EMERGENCY	0	0	5,733,346	0	5,733,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	209,871	43,120,301	0	43,120,301	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	28,870	0	28,870	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	9,839,404	0	9,839,404	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	580,982	0	580,982	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	41,943	0	41,943	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	209,871	53,611,500	0	53,611,500	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,265	1,688	2,953	2,953	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	120,938	161,372	282,310	365	5.00
7.00	00700	OPERATION OF PLANT	0	72,945	97,332	170,277	38	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,589	7,457	13,046	3	8.00
9.00	00900	HOUSEKEEPING	0	2,331	3,111	5,442	53	9.00
10.00	01000	DIETARY	0	28,019	37,386	65,405	16	10.00
11.00	01100	CAFETERIA	0	13,261	17,695	30,956	37	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,498	7,336	12,834	14	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	7,408	9,884	17,292	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,673	43,597	76,270	31	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	2,753	3,674	6,427	12	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,854	67,856	118,710	228	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,488	31,341	54,829	31	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	67,637	90,250	157,887	79	50.00
51.00	05100	RECOVERY ROOM	0	18,974	25,318	44,292	6	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	81	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,059	33,437	58,496	131	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	1,157	1,544	2,701	0	54.01
54.02	03480	ONCOLOGY	0	40,155	53,581	93,736	44	54.02
57.00	05700	CT SCAN	0	1,984	2,648	4,632	9	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,929	11,914	20,843	8	58.00
60.00	06000	LABORATORY	0	20,752	27,689	48,441	99	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,787	7,722	13,509	51	65.00
66.00	06600	PHYSICAL THERAPY	0	14,088	18,798	32,886	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	827	1,103	1,930	8	69.00
69.01	06901	CARDIAC REHAB	0	25,001	33,360	58,361	28	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	44,942	59,968	104,910	144	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	53,739	71,706	125,445	161	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	53,739	71,706	125,445	156	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	10,417	13,900	24,317	35	88.03
90.00	09000	CLINIC	0	1,339	1,787	3,126	0	90.00
90.01	09001	RHEUMATOLOGY	0	3,894	5,196	9,090	14	90.01
91.00	09100	EMERGENCY	0	48,001	64,050	112,051	439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	813,443	1,085,406	1,898,849	2,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	3,944	5,262	9,206	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	107,528	143,478	251,006	564	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	30	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	5,729	7,645	13,374	0	194.01
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	930,644	1,241,791	2,172,435	2,953	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	282,675					5.00
7.00	00700	OPERATION OF PLANT	11,278	181,593				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,798	1,380	16,227			8.00
9.00	00900	HOUSEKEEPING	4,962	576	91	11,124		9.00
10.00	01000	DIETARY	2,987	6,918	67	539	75,932	10.00
11.00	01100	CAFETERIA	5,786	3,274	0	255	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,500	1,357	0	106	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	145	0	0	0	0	14.00
15.00	01500	PHARMACY	5,284	1,829	0	142	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,102	8,067	0	628	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	982	680	0	53	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,153	12,556	3,530	977	68,680	30.00
31.00	03100	INTENSIVE CARE UNIT	6,393	5,799	2,726	451	7,252	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,026	16,699	2,303	1,300	0	50.00
51.00	05100	RECOVERY ROOM	842	4,685	250	365	0	51.00
53.00	05300	ANESTHESIOLOGY	2,288	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,904	6,187	1,214	482	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	1,527	286	0	22	0	54.01
54.02	03480	ONCOLOGY	28,670	9,914	522	772	0	54.02
57.00	05700	CT SCAN	1,791	490	0	38	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,545	2,205	0	172	0	58.00
60.00	06000	LABORATORY	20,690	5,124	0	399	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,607	1,429	0	111	0	65.00
66.00	06600	PHYSICAL THERAPY	2,774	3,478	448	271	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	710	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	299	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	876	204	0	16	0	69.00
69.01	06901	CARDIAC REHAB	2,564	6,173	0	481	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,658	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,281	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,329	11,096	363	864	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,835	13,268	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	14,805	13,268	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,365	2,572	0	0	0	88.03
90.00	09000	CLINIC	20	331	0	26	0	90.00
90.01	09001	RHEUMATOLOGY	632	961	0	75	0	90.01
91.00	09100	EMERGENCY	25,776	11,851	3,951	923	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,184	152,657	15,465	9,468	75,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	58	974	0	76	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	49,485	26,547	762	1,470	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	2,864	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	84	1,415	0	110	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	282,675	181,593	16,227	11,124	75,932	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	40,308					11.00
13.00	01300	NURSING ADMINISTRATION	496	16,307				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	145			14.00
15.00	01500	PHARMACY	1,404	0	1	25,990		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,816	0	0	0	90,914	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	385	0	0	0	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,329	6,363	4	0	27,012	30.00
31.00	03100	INTENSIVE CARE UNIT	1,013	1,210	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,286	0	29	0	49,562	50.00
51.00	05100	RECOVERY ROOM	239	0	1	0	0	51.00
53.00	05300	ANESTHESIOLOGY	859	0	1	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,640	0	2	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
54.02	03480	ONCOLOGY	1,934	0	1	0	0	54.02
57.00	05700	CT SCAN	393	0	2	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	336	0	0	0	0	58.00
60.00	06000	LABORATORY	4,991	0	66	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,936	0	4	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	302	0	1	0	0	69.00
69.01	06901	CARDIAC REHAB	922	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,990	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	395	0	0	0	0	90.01
91.00	09100	EMERGENCY	7,314	8,734	7	0	14,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,990	16,307	139	25,990	90,914	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	6	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	1,318	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,308	16,307	145	25,990	90,914	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	17.01	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
17.01	01701	UTILIZATION REVIEW	0	8,539				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,723	264,265	0	264,265	30.00
31.00	03100	INTENSIVE CARE UNIT	0	816	80,520	0	80,520	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	242,171	0	242,171	50.00
51.00	05100	RECOVERY ROOM	0	0	50,680	0	50,680	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,229	0	3,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	85,056	0	85,056	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	4,536	0	4,536	54.01
54.02	03480	ONCOLOGY	0	0	135,593	0	135,593	54.02
57.00	05700	CT SCAN	0	0	7,355	0	7,355	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	25,109	0	25,109	58.00
60.00	06000	LABORATORY	0	0	79,810	0	79,810	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	21,647	0	21,647	65.00
66.00	06600	PHYSICAL THERAPY	0	0	39,859	0	39,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	710	0	710	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	299	0	299	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,337	0	3,337	69.00
69.01	06901	CARDIAC REHAB	0	0	68,529	0	68,529	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,671	0	1,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	30,271	0	30,271	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	130,707	0	130,707	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	153,710	0	153,710	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	153,676	0	153,676	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	30,290	0	30,290	88.03
90.00	09000	CLINIC	0	0	3,503	0	3,503	90.00
90.01	09001	RHEUMATOLOGY	0	0	11,167	0	11,167	90.01
91.00	09100	EMERGENCY	0	0	185,386	0	185,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,539	1,813,086	0	1,813,086	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	10,314	0	10,314	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	329,840	0	329,840	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	4,212	0	4,212	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	14,983	0	14,983	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,539	2,172,435	0	2,172,435	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,566					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,566				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153	153	28,547,762			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,628	14,628	3,545,283	-8,450,412	45,161,088	5.00
7.00	00700	OPERATION OF PLANT	8,823	8,823	372,104	0	1,801,920	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	676	33,323	0	287,228	8.00
9.00	00900	HOUSEKEEPING	282	282	510,528	0	792,740	9.00
10.00	01000	DIETARY	3,389	3,389	152,306	0	477,251	10.00
11.00	01100	CAFETERIA	1,604	1,604	355,430	0	924,373	11.00
13.00	01300	NURSING ADMINISTRATION	665	665	140,480	0	239,659	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	23,233	14.00
15.00	01500	PHARMACY	896	896	366,107	0	844,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,952	3,952	300,871	0	655,307	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	333	333	117,436	0	156,913	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,151	6,151	2,216,360	0	2,101,437	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841	2,841	302,328	0	1,021,415	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,181	8,181	765,388	0	1,761,613	50.00
51.00	05100	RECOVERY ROOM	2,295	2,295	54,302	0	134,606	51.00
53.00	05300	ANESTHESIOLOGY	0	0	788,674	0	365,614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,031	3,031	1,274,599	0	2,061,613	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140	140	0	0	244,036	54.01
54.02	03480	ONCOLOGY	4,857	4,857	431,587	0	4,580,677	54.02
57.00	05700	CT SCAN	240	240	83,041	0	286,114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	1,080	82,392	0	246,858	58.00
60.00	06000	LABORATORY	2,510	2,510	962,994	0	3,305,713	60.00
65.00	06500	RESPIRATORY THERAPY	700	700	495,553	0	736,034	65.00
66.00	06600	PHYSICAL THERAPY	1,704	1,704	0	0	443,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	113,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	47,825	68.00
69.00	06900	ELECTROCARDIOLOGY	100	100	77,141	0	139,990	69.00
69.01	06901	CARDIAC REHAB	3,024	3,024	268,962	0	409,625	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	264,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	683,967	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,436	5,436	1,400,379	0	2,129,616	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,500	6,500	1,560,211	0	2,370,265	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,500	6,500	1,512,040	0	2,365,327	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,260	1,260	344,141	0	537,702	88.03
90.00	09000	CLINIC	162	162	0	0	3,126	90.00
90.01	09001	RHEUMATOLOGY	471	471	132,328	0	100,915	90.01
91.00	09100	EMERGENCY	5,806	5,806	4,263,243	0	4,118,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,390	98,390	22,909,531	-8,450,412	36,776,990	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	477	477	0	0	9,206	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,006	13,006	5,344,147	0	7,904,010	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	294,084	0	457,508	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	693	693	0	0	13,374	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	930,644	1,241,791	5,553,236		8,450,412	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.267541	11.031670	0.194524		0.187117	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,953		282,675	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000103		0.006259	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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	88,962					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	178,564				8.00
9.00	00900	HOUSEKEEPING	282	1,002	70,004			9.00
10.00	01000	DIETARY	3,389	740	3,389	890		10.00
11.00	01100	CAFETERIA	1,604	0	1,604	0	293,083	11.00
13.00	01300	NURSING ADMINISTRATION	665	0	665	0	3,607	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	896	0	896	0	10,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,952	0	3,952	0	13,206	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	333	0	333	0	2,803	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,151	38,845	6,151	805	38,744	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841	29,996	2,841	85	7,369	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,181	25,348	8,181	0	23,895	50.00
51.00	05100	RECOVERY ROOM	2,295	2,746	2,295	0	1,739	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,031	13,358	3,031	0	41,008	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140	0	140	0	0	54.01
54.02	03480	ONCOLOGY	4,857	5,740	4,857	0	14,059	54.02
57.00	05700	CT SCAN	240	0	240	0	2,859	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	0	2,440	58.00
60.00	06000	LABORATORY	2,510	0	2,510	0	36,288	60.00
65.00	06500	RESPIRATORY THERAPY	700	0	700	0	14,080	65.00
66.00	06600	PHYSICAL THERAPY	1,704	4,931	1,704	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100	0	100	0	2,197	69.00
69.01	06901	CARDIAC REHAB	3,024	0	3,024	0	6,703	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,436	3,997	5,436	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,500	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,500	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,260	0	0	0	0	88.03
90.00	09000	CLINIC	162	0	162	0	0	90.00
90.01	09001	RHEUMATOLOGY	471	0	471	0	2,873	90.01
91.00	09100	EMERGENCY	5,806	43,479	5,806	0	53,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,786	170,182	59,568	890	283,501	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	477	0	477	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,006	8,382	9,266	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	9,582	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	693	0	693	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,139,090	357,227	949,861	695,505	1,157,671	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.044985	2.000554	13.568668	781.466292	3.949977	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	181,593	16,227	11,124	75,932	40,308	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.041242	0.090875	0.158905	85.316854	0.137531	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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	99,289					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	2,942,653				14.00
15.00	01500	PHARMACY	0	22,257	683,967			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	67,293		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	0	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,744	73,972	0	19,994	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,369	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	595,115	0	36,685	0	50.00
51.00	05100	RECOVERY ROOM	0	21,319	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	21,194	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,298	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	1,135	0	0	0	54.01
54.02	03480	ONCOLOGY	0	22,843	0	0	0	54.02
57.00	05700	CT SCAN	0	31,781	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,076	0	0	0	58.00
60.00	06000	LABORATORY	0	1,359,408	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	72,282	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	46,335	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,326	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	3,374	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	264,952	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	683,967	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,217	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	24,822	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	31,108	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	10,409	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	673	0	0	0	90.01
91.00	09100	EMERGENCY	53,176	134,160	0	10,614	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,289	2,814,056	683,967	67,293	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	126,770	0	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	1,827	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	323,764	27,580	1,076,513	978,738	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.260824	0.009372	1.573925	14.544425	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,307	145	25,990	90,914	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.164238	0.000049	0.037999	1.351017	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 9:40 am

		Cost Center Description	UTILIZATION REVIEW (TOTAL PATIENT DAYS)	
			17.01	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	UTILIZATION REVIEW	890	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	805	30.00
31.00	03100	INTENSIVE CARE UNIT	85	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	54.01
54.02	03480	ONCOLOGY	0	54.02
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIAC REHAB	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	88.03
90.00	09000	CLINIC	0	90.00
90.01	09001	RHEUMATOLOGY	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	890	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	VACANT SPACE	0	194.00
194.01	07951	BOARD OF HEALTH	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	209,871	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	235.810112	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,539	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.594382	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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,193,502		4,193,502	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,519,014		1,519,014	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,083,192		3,083,192	0	0	50.00
51.00	05100	RECOVERY ROOM	258,679		258,679	0	0	51.00
53.00	05300	ANESTHESIOLOGY	458,902		458,902	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,750,530		2,750,530	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	294,976		294,976	0	0	54.01
54.02	03480	ONCOLOGY	5,687,719		5,687,719	0	0	54.02
57.00	05700	CT SCAN	360,269		360,269	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,320		343,320	0	0	58.00
60.00	06000	LABORATORY	4,174,757		4,174,757	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	956,380	0	956,380	0	0	65.00
66.00	06600	PHYSICAL THERAPY	600,612	0	600,612	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,678	0	134,678	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,774	0	56,774	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	178,730		178,730	0	0	69.00
69.01	06901	CARDIAC REHAB	626,526		626,526	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	317,012		317,012	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,888,462		1,888,462	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,740,728		2,740,728	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,970,307		2,970,307	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,964,504		2,964,504	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	668,710		668,710	0	0	88.03
90.00	09000	CLINIC	9,804		9,804	0	0	90.00
90.01	09001	RHEUMATOLOGY	148,868		148,868	0	0	90.01
91.00	09100	EMERGENCY	5,733,346		5,733,346	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,262,972		2,262,972		0	92.00
200.00		Subtotal (see instructions)	45,383,273	0	45,383,273	0	0	200.00
201.00		Less Observation Beds	2,262,972		2,262,972		0	201.00
202.00		Total (see instructions)	43,120,301	0	43,120,301	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | 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	1,639,860		1,639,860			30.00
31.00	03100	INTENSIVE CARE UNIT	355,470		355,470			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,160	4,465,344	4,687,504	0.657747	0.000000	50.00
51.00	05100	RECOVERY ROOM	30,943	562,345	593,288	0.436009	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	24,665	517,812	542,477	0.845938	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,582	9,713,052	10,160,634	0.270705	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,359	1,417,084	1,434,443	0.205638	0.000000	54.01
54.02	03480	ONCOLOGY	1,567	9,633,041	9,634,608	0.590343	0.000000	54.02
57.00	05700	CT SCAN	281,216	12,119,714	12,400,930	0.029052	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,456	2,887,203	2,960,659	0.115961	0.000000	58.00
60.00	06000	LABORATORY	667,179	14,479,073	15,146,252	0.275630	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	835,275	1,554,400	2,389,675	0.400213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	263,143	1,864,641	2,127,784	0.282271	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,859	465,953	609,812	0.220852	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,246	207,034	229,280	0.247619	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,995	1,859,219	1,882,214	0.094957	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	1,432,573	1,432,573	0.437343	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,704	217,504	329,208	0.962954	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	521,858	2,474,672	2,996,530	0.630216	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,191,668	2,191,668			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,493,141	2,493,141			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,191,921	2,191,921			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	659,311	659,311			88.03
90.00	09000	CLINIC	0	13,248	13,248	0.740036	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	92,215	92,215	1.614358	0.000000	90.01
91.00	09100	EMERGENCY	253,921	25,110,947	25,364,868	0.226035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,227	1,989,331	2,070,558	1.092929	0.000000	92.00
200.00		Subtotal (see instructions)	6,017,685	100,612,446	106,630,131			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,017,685	100,612,446	106,630,131			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	54.01
54.02	03480	ONCOLOGY	0.000000	54.02
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	4,193,502		4,193,502	0	4,193,502	30.00
31.00	03100	INTENSIVE CARE UNIT	1,519,014		1,519,014	0	1,519,014	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,083,192		3,083,192	0	3,083,192	50.00
51.00	05100	RECOVERY ROOM	258,679		258,679	0	258,679	51.00
53.00	05300	ANESTHESIOLOGY	458,902		458,902	0	458,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,750,530		2,750,530	0	2,750,530	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	294,976		294,976	0	294,976	54.01
54.02	03480	ONCOLOGY	5,687,719		5,687,719	0	5,687,719	54.02
57.00	05700	CT SCAN	360,269		360,269	0	360,269	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,320		343,320	0	343,320	58.00
60.00	06000	LABORATORY	4,174,757		4,174,757	0	4,174,757	60.00
65.00	06500	RESPIRATORY THERAPY	956,380	0	956,380	0	956,380	65.00
66.00	06600	PHYSICAL THERAPY	600,612	0	600,612	0	600,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,678	0	134,678	0	134,678	67.00
68.00	06800	SPEECH PATHOLOGY	56,774	0	56,774	0	56,774	68.00
69.00	06900	ELECTROCARDIOLOGY	178,730		178,730	0	178,730	69.00
69.01	06901	CARDIAC REHAB	626,526		626,526	0	626,526	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	317,012		317,012	0	317,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,888,462		1,888,462	0	1,888,462	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,740,728		2,740,728	0	2,740,728	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,970,307		2,970,307	0	2,970,307	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,964,504		2,964,504	0	2,964,504	88.02
88.03	08803	RURAL HEALTH CLINIC IV	668,710		668,710	0	668,710	88.03
90.00	09000	CLINIC	9,804		9,804	0	9,804	90.00
90.01	09001	RHEUMATOLOGY	148,868		148,868	0	148,868	90.01
91.00	09100	EMERGENCY	5,733,346		5,733,346	0	5,733,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,262,972		2,262,972		2,262,972	92.00
200.00		Subtotal (see instructions)	45,383,273	0	45,383,273	0	45,383,273	200.00
201.00		Less Observation Beds	2,262,972		2,262,972		2,262,972	201.00
202.00		Total (see instructions)	43,120,301	0	43,120,301	0	43,120,301	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 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	1,639,860		1,639,860			30.00
31.00	03100	INTENSIVE CARE UNIT	355,470		355,470			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,160	4,465,344	4,687,504	0.657747	0.000000	50.00
51.00	05100	RECOVERY ROOM	30,943	562,345	593,288	0.436009	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	24,665	517,812	542,477	0.845938	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,582	9,713,052	10,160,634	0.270705	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,359	1,417,084	1,434,443	0.205638	0.000000	54.01
54.02	03480	ONCOLOGY	1,567	9,633,041	9,634,608	0.590343	0.000000	54.02
57.00	05700	CT SCAN	281,216	12,119,714	12,400,930	0.029052	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,456	2,887,203	2,960,659	0.115961	0.000000	58.00
60.00	06000	LABORATORY	667,179	14,479,073	15,146,252	0.275630	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	835,275	1,554,400	2,389,675	0.400213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	263,143	1,864,641	2,127,784	0.282271	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,859	465,953	609,812	0.220852	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,246	207,034	229,280	0.247619	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,995	1,859,219	1,882,214	0.094957	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	1,432,573	1,432,573	0.437343	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,704	217,504	329,208	0.962954	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	521,858	2,474,672	2,996,530	0.630216	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,191,668	2,191,668	1.250522	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,493,141	2,493,141	1.191392	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,191,921	2,191,921	1.352468	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	659,311	659,311	1.014256	0.000000	88.03
90.00	09000	CLINIC	0	13,248	13,248	0.740036	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	92,215	92,215	1.614358	0.000000	90.01
91.00	09100	EMERGENCY	253,921	25,110,947	25,364,868	0.226035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,227	1,989,331	2,070,558	1.092929	0.000000	92.00
200.00		Subtotal (see instructions)	6,017,685	100,612,446	106,630,131			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,017,685	100,612,446	106,630,131			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 9:40 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
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	54.01
54.02	03480	ONCOLOGY	0.000000	54.02
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	242,171	4,687,504	0.051663	38,532	1,991	50.00
51.00	05100	RECOVERY ROOM	50,680	593,288	0.085422	6,504	556	51.00
53.00	05300	ANESTHESIOLOGY	3,229	542,477	0.005952	2,981	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,056	10,160,634	0.008371	213,351	1,786	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	4,536	1,434,443	0.003162	2,567	8	54.01
54.02	03480	ONCOLOGY	135,593	9,634,608	0.014074	0	0	54.02
57.00	05700	CT SCAN	7,355	12,400,930	0.000593	131,893	78	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,109	2,960,659	0.008481	42,717	362	58.00
60.00	06000	LABORATORY	79,810	15,146,252	0.005269	291,133	1,534	60.00
65.00	06500	RESPIRATORY THERAPY	21,647	2,389,675	0.009059	334,818	3,033	65.00
66.00	06600	PHYSICAL THERAPY	39,859	2,127,784	0.018733	93,729	1,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	710	609,812	0.001164	49,882	58	67.00
68.00	06800	SPEECH PATHOLOGY	299	229,280	0.001304	8,909	12	68.00
69.00	06900	ELECTROCARDIOLOGY	3,337	1,882,214	0.001773	13,399	24	69.00
69.01	06901	CARDIAC REHAB	68,529	1,432,573	0.047836	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,671	329,208	0.005076	81,468	414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,271	2,996,530	0.010102	216,837	2,190	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	130,707	2,191,668	0.059638	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	153,710	2,493,141	0.061653	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	153,676	2,191,921	0.070110	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	30,290	659,311	0.045942	0	0	88.03
90.00	09000	CLINIC	3,503	13,248	0.264417	0	0	90.00
90.01	09001	RHEUMATOLOGY	11,167	92,215	0.121097	0	0	90.01
91.00	09100	EMERGENCY	185,386	25,364,868	0.007309	16,577	121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	142,608	2,070,558	0.068874	533	37	92.00
200.00		Total (lines 50 through 199)	1,610,909	104,634,801		1,545,830	13,978	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
54.02	03480	ONCOLOGY	0	0	0	0	0	54.02
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,687,504	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	593,288	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	542,477	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,160,634	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	1,434,443	0.000000	54.01
54.02	03480	ONCOLOGY	0	0	0	9,634,608	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	12,400,930	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,960,659	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	15,146,252	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,389,675	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,127,784	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	609,812	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	229,280	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,882,214	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	1,432,573	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	329,208	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,996,530	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,191,668	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,493,141	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,191,921	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	659,311	0.000000	88.03
90.00	09000	CLINIC	0	0	0	13,248	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	92,215	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	25,364,868	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,070,558	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	104,634,801		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	38,532	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	6,504	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,981	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	213,351	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	2,567	0	0	0	54.01
54.02	03480	ONCOLOGY	0.000000	0	0	0	0	54.02
57.00	05700	CT SCAN	0.000000	131,893	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	42,717	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	291,133	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	334,818	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	93,729	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	49,882	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,909	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,399	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	81,468	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	216,837	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	16,577	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	533	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,545,830	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.657747	0	1,016,620	0	0	50.00
51.00	05100	RECOVERY ROOM	0.436009	0	62,698	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.845938	0	55,282	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270705	0	1,562,750	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.205638	0	292,802	0	0	54.01
54.02	03480	ONCOLOGY	0.590343	0	4,293,494	0	0	54.02
57.00	05700	CT SCAN	0.029052	0	2,348,129	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115961	0	590,040	0	0	58.00
60.00	06000	LABORATORY	0.275630	0	3,075,076	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.400213	0	238,884	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.282271	0	394,452	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220852	0	53,044	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.247619	0	24,037	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094957	0	347,715	0	0	69.00
69.01	06901	CARDIAC REHAB	0.437343	0	414,011	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.962954	0	53,235	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.630216	0	439,401	203	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.740036	0	1,452	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.614358	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.226035	0	3,265,268	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.092929	0	333,241	0	0	92.00
200.00		Subtotal (see instructions)		0	18,861,631	203	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	18,861,631	203	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	668,679	0	50.00
51.00	05100	RECOVERY ROOM	27,337	0	51.00
53.00	05300	ANESTHESIOLOGY	46,765	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,044	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	60,211	0	54.01
54.02	03480	ONCOLOGY	2,534,634	0	54.02
57.00	05700	CT SCAN	68,218	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	68,422	0	58.00
60.00	06000	LABORATORY	847,583	0	60.00
65.00	06500	RESPIRATORY THERAPY	95,604	0	65.00
66.00	06600	PHYSICAL THERAPY	111,342	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,715	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,952	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,018	0	69.00
69.01	06901	CARDIAC REHAB	181,065	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	276,918	128	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	1,075	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	90.01
91.00	09100	EMERGENCY	738,065	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	364,209	0	92.00
200.00		Subtotal (see instructions)	6,615,119	128	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,615,119	128	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,094	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,935	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)	805	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	159	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)	414	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)	53	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,193,502	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)	318,418	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,875,084	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)	3,875,084	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,002.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	829,089	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)	829,089	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,519,014	85	17,870.75	33	589,735	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)	572,401	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)	1,991,225	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)	106,139	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	106,139	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,130	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,002.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,262,972	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

	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	264,265	4,193,502	0.063018	2,262,972	142,608	90.00
91.00	Nursing Program cost	0	4,193,502	0.000000	2,262,972	0	91.00
92.00	Allied health cost	0	4,193,502	0.000000	2,262,972	0	92.00
93.00	All other Medical Education	0	4,193,502	0.000000	2,262,972	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 9:40 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,094	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,935	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)	805	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	159	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)	9	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,193,502	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)	318,418	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,875,084	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)	3,875,084	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,002.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	18,024	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)	18,024	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 9:40 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	1,519,014	85	17,870.75	1	17,871	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)	19,704	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)	55,599	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,130	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,002.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,262,972	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 Date/Time Prepared: 5/30/2024 9:40 am

Title XIX | Hospital | Cost

	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	264,265	4,193,502	0.063018	2,262,972	142,608	90.00
91.00	Nursing Program cost	0	4,193,502	0.000000	2,262,972	0	91.00
92.00	Allied health cost	0	4,193,502	0.000000	2,262,972	0	92.00
93.00	All other Medical Education	0	4,193,502	0.000000	2,262,972	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		760,691		30.00
31.00	03100	INTENSIVE CARE UNIT		143,055		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.657747	38,532	25,344	50.00
51.00	05100	RECOVERY ROOM	0.436009	6,504	2,836	51.00
53.00	05300	ANESTHESIOLOGY	0.845938	2,981	2,522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270705	213,351	57,755	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.205638	2,567	528	54.01
54.02	03480	ONCOLOGY	0.590343	0	0	54.02
57.00	05700	CT SCAN	0.029052	131,893	3,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115961	42,717	4,954	58.00
60.00	06000	LABORATORY	0.275630	291,133	80,245	60.00
65.00	06500	RESPIRATORY THERAPY	0.400213	334,818	133,999	65.00
66.00	06600	PHYSICAL THERAPY	0.282271	93,729	26,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220852	49,882	11,017	67.00
68.00	06800	SPEECH PATHOLOGY	0.247619	8,909	2,206	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094957	13,399	1,272	69.00
69.01	06901	CARDIAC REHAB	0.437343	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.962954	81,468	78,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.630216	216,837	136,654	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.740036	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.614358	0	0	90.01
91.00	09100	EMERGENCY	0.226035	16,577	3,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.092929	533	583	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,545,830	572,401	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,545,830		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.657747	111	73	50.00
51.00	05100	RECOVERY ROOM	0.436009	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.845938	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270705	972	263	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.205638	0	0	54.01
54.02	03480	ONCOLOGY	0.590343	0	0	54.02
57.00	05700	CT SCAN	0.029052	9,023	262	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115961	0	0	58.00
60.00	06000	LABORATORY	0.275630	4,683	1,291	60.00
65.00	06500	RESPIRATORY THERAPY	0.400213	33,449	13,387	65.00
66.00	06600	PHYSICAL THERAPY	0.282271	25,578	7,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220852	11,673	2,578	67.00
68.00	06800	SPEECH PATHOLOGY	0.247619	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094957	0	0	69.00
69.01	06901	CARDIAC REHAB	0.437343	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.962954	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.630216	7,124	4,490	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.740036	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.614358	0	0	90.01
91.00	09100	EMERGENCY	0.226035	36	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.092929	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		92,649	29,572	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)		92,649		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 9:40 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		14,506		30.00
31.00	03100	INTENSIVE CARE UNIT		4,335		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.657747	0	0	50.00
51.00	05100	RECOVERY ROOM	0.436009	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.845938	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.270705	4,724	1,279	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.205638	0	0	54.01
54.02	03480	ONCOLOGY	0.590343	0	0	54.02
57.00	05700	CT SCAN	0.029052	7,369	214	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.115961	0	0	58.00
60.00	06000	LABORATORY	0.275630	14,627	4,032	60.00
65.00	06500	RESPIRATORY THERAPY	0.400213	2,357	943	65.00
66.00	06600	PHYSICAL THERAPY	0.282271	2,696	761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220852	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.247619	401	99	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094957	1,065	101	69.00
69.01	06901	CARDIAC REHAB	0.437343	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.962954	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.630216	6,450	4,065	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.250522	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.191392	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.352468	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.014256	0	0	88.03
90.00	09000	CLINIC	0.740036	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.614358	0	0	90.01
91.00	09100	EMERGENCY	0.226035	14,853	3,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.092929	4,440	4,853	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,982	19,704	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)		58,982		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,615,247	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,615,247	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,681,399	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	64,245	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,135,238	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,481,916	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,481,916	30.00
31.00	Primary payer payments	5,741	31.00
32.00	Subtotal (line 30 minus line 31)	3,476,175	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)	516,518	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	335,737	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	332,123	36.00
37.00	Subtotal (see instructions)	3,811,912	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,811,912	40.00
40.01	Sequestration adjustment (see instructions)	76,238	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	3,855,497	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)	-119,823	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	Hospital	Cost

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

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,233,033		3,165,297	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	09/20/2023	233,600	09/20/2023	690,200	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)		233,600		690,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,466,633		3,855,497	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		333,216		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		119,823	6.02
7.00	Total Medicare program liability (see instructions)		1,799,849		3,735,674	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		08001		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		103,051		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		103,051		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		31,276		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		134,327		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2
Component CCN: 15-Z333 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	107,200	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	29,868	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	53	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	137,068	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	137,068	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	137,068	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	137,068	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	137,068	0	19.00
19.01	Sequestration adjustment (see instructions)	2,741	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	103,051	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	31,276	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,991,225	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,991,225	4.00
5.00	Primary payer payments	11,674	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,999,463	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,999,463	19.00
20.00	Deductibles (exclude professional component)	187,156	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,812,307	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,812,307	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,345	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,274	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,940	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,836,581	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,836,581	30.00
30.01	Sequestration adjustment (see instructions)	36,732	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,466,633	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	333,216	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 9:40 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	55,599		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)	55,599	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)	55,599	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	18,841		8.00
9.00	Ancillary service charges	58,982	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)	77,823	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)	77,823	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	22,224	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)	55,599	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)	55,599	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)	55,599	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	55,599	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	55,599	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)	55,599	0	40.00
41.00	Interim payments	55,599	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 9:40 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	13,137,764	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	13,037,650	0	0	0	4.00
5.00	Other receivable	416,924	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,920,086	0	0	0	6.00
7.00	Inventory	562,062	0	0	0	7.00
8.00	Prepaid expenses	460,921	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)	19,695,235	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	260,501	0	0	0	12.00
13.00	Land improvements	463,796	0	0	0	13.00
14.00	Accumulated depreciation	-349,893	0	0	0	14.00
15.00	Buildings	35,938,045	0	0	0	15.00
16.00	Accumulated depreciation	-26,660,850	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,175,379	0	0	0	23.00
24.00	Accumulated depreciation	-21,618,117	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,208,861	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,561,905	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	245,303	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,807,208	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,711,304	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,364,695	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,671,343	0	0	0	38.00
39.00	Payroll taxes payable	130,515	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	1,655,367	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,821,920	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,966,629	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,966,629	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,788,549	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,922,755				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)	27,922,755	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,711,304	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 Date/Time Prepared: 5/30/2024 9:40 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		36,362,463		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,607,312				2.00
3.00	Total (sum of line 1 and line 2)		27,755,151		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	ADJUSTMENT	167,604		0		0	9.00
10.00	Total additions (sum of line 4-9)		167,604		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,922,755		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)		27,922,755		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00	ADJUSTMENT		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: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2024 9:40 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,645,178		2,645,178	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)	2,645,178		2,645,178	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,175,806		2,175,806	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)	2,175,806		2,175,806	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,820,984		4,820,984	17.00
18.00	Ancillary services	3,739,298	66,877,011	70,616,309	18.00
19.00	Outpatient services	321,890	31,966,624	32,288,514	19.00
20.00	RURAL HEALTH CLINIC	0	2,191,668	2,191,668	20.00
20.01	RURAL HEALTH CLINIC II	0	2,493,141	2,493,141	20.01
20.02	RURAL HEALTH CLINIC III	0	2,191,921	2,191,921	20.02
20.03	RURAL HEALTH CLINIC IV	0	659,311	659,311	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	Other Patient Service Revenue - NRCCs	0	7,001,101	7,001,101	27.01
27.02	OTHER (SPECIFY)	0	0	0	27.02
27.03	OTHER (SPECIFY)	0	0	0	27.03
27.04	Century Villa Net Revenue	8,870,778	0	8,870,778	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,752,950	113,380,777	131,133,727	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,198,615		29.00
30.00	Century Villa Operating Expenses	8,544,763			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)		8,544,763		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)		70,743,378		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/30/2024 9:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	131,133,727	1.00
2.00	Less contractual allowances and discounts on patients' accounts	77,244,786	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,888,941	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,743,378	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,854,437	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	263,046	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	14,095	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	67,691	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	48	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	183,686	23.00
24.00	Misc Revenue	2,209,730	24.00
24.01	340B Program Revenue	1,212,363	24.01
24.02	UPL Revenue	4,276,607	24.02
24.50	COVID-19 PHE Funding	19,859	24.50
25.00	Total other income (sum of lines 6-24)	8,247,125	25.00
26.00	Total (line 5 plus line 25)	-8,607,312	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)	-8,607,312	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	311,384	31,838	343,222	0	343,222	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	315,661	62,494	378,155	0	378,155	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	47,563	0	47,563	0	47,563	5.00
6.00	Clinical Psychologist	256,359	55,543	311,902	0	311,902	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	156,095	0	156,095	0	156,095	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,087,062	149,875	1,236,937	0	1,236,937	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	137,583	137,583	-26	137,557	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	523	523	-175	348	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	138,106	138,106	-201	137,905	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,087,062	287,981	1,375,043	-201	1,374,842	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	3,600	0	3,600	0	3,600	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)	3,600	0	3,600	0	3,600	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,998	6,998	-44	6,954	29.00
30.00	Administrative Costs	336,919	77,694	414,613	-31,691	382,922	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	336,919	84,692	421,611	-31,735	389,876	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,427,581	372,673	1,800,254	-31,936	1,768,318	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	343,222	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	855	379,010	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	47,563	5.00
6.00	Clinical Psychologist	-15,000	296,902	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	156,095	9.00
10.00	Subtotal (sum of lines 1 through 9)	-14,145	1,222,792	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	137,557	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	348	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	137,905	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-14,145	1,360,697	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	3,600	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	3,600	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	6,954	29.00
30.00	Administrative Costs	-1,874	381,048	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,874	388,002	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-16,019	1,752,299	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	353,262	35,524	388,786	0	388,786	1.00
2.00	Physician Assistant	543,327	110,823	654,150	0	654,150	2.00
3.00	Nurse Practitioner	58,350	11,656	70,006	0	70,006	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	184,479	0	184,479	0	184,479	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	14,153	6,127	20,280	0	20,280	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	154,973	0	154,973	0	154,973	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,308,544	164,130	1,472,674	0	1,472,674	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	98,287	98,287	4	98,291	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	62	62	26	88	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	98,349	98,349	30	98,379	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,308,544	262,479	1,571,023	30	1,571,053	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	1,574	0	1,574	0	1,574	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)	1,574	0	1,574	0	1,574	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,671	4,671	7	4,678	29.00
30.00	Administrative Costs	246,024	113,253	359,277	4,740	364,017	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	246,024	117,924	363,948	4,747	368,695	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,556,142	380,403	1,936,545	4,777	1,941,322	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8513 | Date/Time Prepared: 5/30/2024 9:40 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	388,786	1.00
2.00	Physician Assistant	0	654,150	2.00
3.00	Nurse Practitioner	0	70,006	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	184,479	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	20,280	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	154,973	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,472,674	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	98,291	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	88	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	98,379	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,571,053	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	1,574	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	1,574	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	4,678	29.00
30.00	Administrative Costs	0	364,017	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	368,695	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,941,322	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	531,742	67,308	599,050	0	599,050	1.00
2.00	Physician Assistant	131,599	32,387	163,986	0	163,986	2.00
3.00	Nurse Practitioner	261,745	57,202	318,947	0	318,947	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	169,853	0	169,853	0	169,853	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	74,885	18,392	93,277	0	93,277	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	164,039	0	164,039	0	164,039	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,333,863	175,289	1,509,152	0	1,509,152	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	128,876	128,876	22	128,898	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	149	149	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	128,876	128,876	171	129,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,333,863	304,165	1,638,028	171	1,638,199	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	798	0	798	0	798	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)	798	0	798	0	798	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	210	2,829	3,039	37	3,076	29.00
30.00	Administrative Costs	154,036	122,694	276,730	26,951	303,681	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	154,246	125,523	279,769	26,988	306,757	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,488,907	429,688	1,918,595	27,159	1,945,754	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	599,050	1.00
2.00	Physician Assistant	0	163,986	2.00
3.00	Nurse Practitioner	0	318,947	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	169,853	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	93,277	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	164,039	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,509,152	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	128,898	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	149	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	129,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,638,199	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	798	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	798	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	3,076	29.00
30.00	Administrative Costs	0	303,681	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	306,757	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,945,754	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8572 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	122,746	15,055	137,801	0	137,801	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	78,022	12,795	90,817	0	90,817	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	200,768	27,850	228,618	0	228,618	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	51,311	51,311	0	51,311	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	51,311	51,311	0	51,311	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	200,768	79,161	279,929	0	279,929	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	130	0	130	0	130	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)	130	0	130	0	130	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	691	691	0	691	29.00
30.00	Administrative Costs	143,243	22,448	165,691	0	165,691	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	143,243	23,139	166,382	0	166,382	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	344,141	102,300	446,441	0	446,441	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8572 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 9:40 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	137,801	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	90,817	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	228,618	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	51,311	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	51,311	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	279,929	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	130	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	130	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	691	29.00
30.00	Administrative Costs	0	165,691	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	166,382	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	446,441	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 9:40 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.90	3,092	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.32	4,820	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.22	7,912		3	7,912	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	1.84	1,744			1,744	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.06	9,656			9,656	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)	1,360,697	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	3,600	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,364,297	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.997361	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	388,002	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	988,429	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,376,431	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,376,431	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,372,799	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,733,496	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 9:40 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.93	1,988	1	1		1.00
2.00	Physician Assistant	2.94	7,734	1	3		2.00
3.00	Nurse Practitioner	0.28	836	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.15	10,558		4	10,558	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	0.17	146			146	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)	4.32	10,704			10,704	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)	1,571,053	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	1,574	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,572,627	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.998999	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	368,695	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,028,985	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,397,680	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,397,680	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,396,281	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,967,334	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 9:40 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.78	2,900	1	2		1.00
2.00	Physician Assistant	0.88	1,676	1	1		2.00
3.00	Nurse Practitioner	1.76	3,303	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.42	7,879		5	7,879	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	0.89	830			830	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.31	8,709			8,709	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)	1,638,199	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	798	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,638,997	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999513	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	306,757	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,018,750	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,325,507	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,325,507	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,324,861	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,963,060	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8572 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 9:40 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.48	1,300	4,200	2,016		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.40	1,519	2,100	840		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.88	2,819		2,856	2,856	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.88	2,819			2,856	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)	279,929	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	130	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	280,059	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999536	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	166,382	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	222,269	15.00
16.00	Total overhead (sum of lines 14 and 15)	388,651	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	388,651	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	388,471	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	668,400	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8515	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,733,496	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		212,871	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,520,625	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,656	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)		9,656	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		261.04	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	274.95	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	261.04	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	557	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	145,399	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	33	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	8,614	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	8,614	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	154,013	16.00
16.01	Total program charges (see instructions)(from contractor's records)		108,384	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,500	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,657	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.)		100,862	16.04
16.05	Total program cost (see instructions)	0	111,519	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,278	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,709	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		111,519	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,969	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)		124,488	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)		124,488	26.00
26.01	Sequestration adjustment (see instructions)		2,490	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		111,025	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)		10,973	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: 15-1333 Component CCN: 15-8513	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,967,334	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		117,382	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,849,952	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,704	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)		10,704	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		266.25	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	227.72	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	227.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,263	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	287,610	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	5	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,139	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,139	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	288,749	16.00
16.01	Total program charges (see instructions)(from contractor's records)		253,348	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		30,060	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,260	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.)		171,274	16.04
16.05	Total program cost (see instructions)	0	205,534	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,397	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,457	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		205,534	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,403	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)		228,937	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)		228,937	26.00
26.01	Sequestration adjustment (see instructions)		4,579	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		194,065	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)		30,293	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: 15-1333 Component CCN: 15-8514	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,963,060	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		99,788	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,863,272	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,709	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)		8,709	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		328.77	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	304.29	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	304.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	860	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	261,689	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	16	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	4,869	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	4,869	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	266,558	16.00
16.01	Total program charges (see instructions)(from contractor's records)		174,732	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,555	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,000	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.)		186,841	16.04
16.05	Total program cost (see instructions)	0	196,841	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,007	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,993	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		196,841	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,306	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)		216,147	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)		216,147	26.00
26.01	Sequestration adjustment (see instructions)		4,323	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		192,657	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)		19,167	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: 15-1333 Component CCN: 15-8572	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		668,400	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		75,955	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		592,445	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,856	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,856	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		207.44	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	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	408	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	51,408	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	51,408	16.00
16.01	Total program charges (see instructions)(from contractor's records)		70,606	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,630	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,643	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.)		35,846	16.04
16.05	Total program cost (see instructions)	0	38,489	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,957	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,604	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		38,489	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,395	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)		53,884	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)		53,884	26.00
26.01	Sequestration adjustment (see instructions)		1,078	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		37,394	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)		15,412	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: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,222,792	1,222,792	1,222,792	1,222,792	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003395	0.003318	0.000120	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,151	4,057	147	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	84,194	11,884	1,532	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	88,345	15,941	1,679	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,360,697	1,360,697	1,360,697	1,360,697	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,372,799	1,372,799	1,372,799	1,372,799	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.064926	0.011715	0.001234	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	89,130	16,082	1,694	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	177,475	32,023	3,373	0	10.00
11.00	Total number of injections/infusions (from your records)	396	387	14	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	448.17	82.75	240.93	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	58	6	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)	6,723	4,800	1,446	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)		212,871	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)		12,969	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,472,674	1,472,674	1,472,674	1,472,674	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001104	0.003435	0.000022	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,626	5,059	32	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	34,103	21,000	328	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	35,729	26,059	360	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,571,053	1,571,053	1,571,053	1,571,053	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,396,281	1,396,281	1,396,281	1,396,281	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.022742	0.016587	0.000229	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	31,754	23,160	320	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	67,483	49,219	680	0	10.00
11.00	Total number of injections/infusions (from your records)	154	479	3	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	438.20	102.75	226.67	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	136	1	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)	9,202	13,974	227	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)		117,382	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)		23,403	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/30/2024 9:40 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,509,152	1,509,152	1,509,152	1,509,152	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001062	0.002241	0.000079	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,603	3,382	119	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	35,683	13,070	1,313	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	37,286	16,452	1,432	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,638,199	1,638,199	1,638,199	1,638,199	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,324,861	1,324,861	1,324,861	1,324,861	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.022760	0.010043	0.000874	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	30,154	13,306	1,158	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	67,440	29,758	2,590	0	10.00
11.00	Total number of injections/infusions (from your records)	162	342	12	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	416.30	87.01	215.83	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	28	78	4	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)	11,656	6,787	863	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)		99,788	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)		19,306	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-1333 Component CCN: 15-8572	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/30/2024 9:40 am
	Title XVIII	RHC IV	Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	228,618	228,618	228,618	228,618	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001749	0.013371	0.001088	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	400	3,057	249	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,391	14,649	3,064	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,791	17,706	3,313	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	279,929	279,929	279,929	279,929	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	388,471	388,471	388,471	388,471	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.038549	0.063252	0.011835	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	14,975	24,572	4,598	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	25,766	42,278	7,911	0	10.00
11.00	Total number of injections/infusions (from your records)	45	344	28	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	572.58	122.90	282.54	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	86	11	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,718	10,569	3,108	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)		75,955	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)		15,395	16.00

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

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/30/2024 9:40 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		111,025	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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)		111,025	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	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		10,973	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		121,998	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

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

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/30/2024 9:40 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		194,065	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)		194,065	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		30,293	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		224,358	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1333 Component CCN: 15-8514	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/30/2024 9:40 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		192,657	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)		192,657	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		19,167	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		211,824	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

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

Provider CCN: 15-1333 | Component CCN: 15-8572 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/30/2024 9:40 am

RHC IV | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		37,394	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)		37,394	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		15,412	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		52,806	7.00

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