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: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 4/26/2024 1:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 4/26/2024 Time: 1:37 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) 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	Brad Smith		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	Brad Smith			2
3	Signatory Title	PRESIDENT & CEO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	67,103	-382,798	0	-3,804	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	9,825	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		161,997		0	10.00
200.00	TOTAL	0	76,928	-220,801	0	-3,804	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	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	RUSH SWING BEDS	15Z304	99915		08/01/2000	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	RMH HEALTHCARE ASSOC	158539	99915		06/12/2019	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/26/2024 1:37 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 4/26/2024 1:37 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/26/2024 1:37 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 4/26/2024 1:37 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	172,701	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	Y	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 4/26/2024 1:37 pm

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

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

		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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 4/26/2024 1:37 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/22/2024	Y	02/22/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 4/26/2024 1:37 pm

		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.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON	HACKETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929	LHACKETT@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 4/26/2024 1:37 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 4/26/2024 1:37 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	19,608.00	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)		23	8,395	19,608.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	2,088.00	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	21,696.00	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
26.25	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	404	21	817			1.00
2.00	HMO and other (see instructions)	116	54				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	43	0	43			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)	447	21	860			7.00
8.00	INTENSIVE CARE UNIT	23	1	87			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)	470	22	947	0.00	263.88	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	2,692	169	10,717	0.00	28.56	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	292.44	27.00
28.00	Observation Bed Days		12	680			28.00
29.00	Ambulance Trips	111					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	137	5	279	1.00
2.00	HMO and other (see instructions)			31	19		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	137	5	279	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
26.25	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: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 4/26/2024 1:37 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	201 CONRAD HARCOURT WAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE	IN	46173	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	05:00	08:00	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 4/26/2024 1:37 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		RUSH				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	05:00	08:00	05:00	08:00	05:00	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	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 4/26/2024 1:37 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.310437	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,253,378	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	23,648,128	6.00
7.00	Medicaid cost (line 1 times line 6)	7,341,254	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	6,087,876	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)	6,087,876	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)	41,906	18,488	60,394	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	13,009	18,488	31,497	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)	13,009	18,488	31,497	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)	3,501,352	26.00
27.00	Medicare reimbursable bad debts (see instructions)	367,247	27.00
27.01	Medicare allowable bad debts (see instructions)	564,995	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,936,357	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,109,302	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,140,799	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,228,675	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 4/26/2024 1:37 pm

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

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,300,439	2,300,439	0	2,300,439	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	570,344	6,177,951	6,748,295	17,194	6,765,489	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,285,212	6,292,622	9,577,834	-137,556	9,440,278	5.00
7.00	00700	OPERATION OF PLANT	437,675	926,988	1,364,663	42,986	1,407,649	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,192	99,192	0	99,192	8.00
9.00	00900	HOUSEKEEPING	585,813	273,521	859,334	42,986	902,320	9.00
10.00	01000	DIETARY	378,116	94,795	472,911	-300,527	172,384	10.00
11.00	01100	CAFETERIA	0	0	0	334,916	334,916	11.00
13.00	01300	NURSING ADMINISTRATION	216,796	4,964	221,760	0	221,760	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,718	66,697	231,415	10,526	241,941	14.00
15.00	01500	PHARMACY	587,151	5,299,026	5,886,177	0	5,886,177	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,348	39,978	234,326	0	234,326	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,929,442	94,295	2,023,737	-42,978	1,980,759	30.00
31.00	03100	INTENSIVE CARE UNIT	100,068	249,342	349,410	-332	349,078	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,795,596	1,292,319	3,087,915	-1,020,755	2,067,160	50.00
51.00	05100	RECOVERY ROOM	0	38,000	38,000	213,112	251,112	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,307,899	708,402	2,016,301	-78,473	1,937,828	54.00
54.01	05401	ONCOLOGY	401,896	223,734	625,630	-7,028	618,602	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	879,496	1,210,777	2,090,273	-98,381	1,991,892	60.00
65.00	06500	RESPIRATORY THERAPY	175,579	35,190	210,769	-82	210,687	65.00
66.00	06600	PHYSICAL THERAPY	682,902	59,894	742,796	-289,570	453,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	-10,819	4,744	-6,075	248,022	241,947	67.00
68.00	06800	SPEECH PATHOLOGY	-10,333	652	-9,681	40,163	30,482	68.00
69.00	06900	ELECTROCARDIOLOGY	109,855	10,194	120,049	71,792	191,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,533,703	1,533,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,786,610	1,786,610	0	1,786,610	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,407	5,820	59,227	-2,620	56,607	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,232,891	197,854	2,430,745	-254,835	2,175,910	88.00
90.00	09000	CLINIC	937,891	174,472	1,112,363	-139,954	972,409	90.00
90.01	09001	SURGICAL ASSOCIATES	0	616,814	616,814	-220	616,594	90.01
90.02	09002	ORTHOPAEDICS	-3,220	420,690	417,470	253,498	670,968	90.02
90.03	09003	RHEUMATOLOGY	-34,917	6,335	-28,582	63,070	34,488	90.03
90.04	09004	SPECIALTY CLINIC	2,905,419	399,439	3,304,858	-742,720	2,562,138	90.04
90.05	09005	PEDIATRICS	484,081	32,092	516,173	-23,116	493,057	90.05
90.06	09006	WOMEN'S HEALTH	-21,150	6,042	-15,108	49,615	34,507	90.06
90.07	09007	PAIN MANAGEMENT	633,360	135,994	769,354	-405	768,949	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	856,663	1,638,038	2,494,701	-38,152	2,456,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	291,830	27,264	319,094	-286	318,808	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,118,009	30,951,180	53,069,189	-256,407	52,812,782	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	159,033	685	159,718	0	159,718	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	0	0	256,407	256,407	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	22,277,042	30,951,865	53,228,907	0	53,228,907	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-61,868	2,238,571		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-180,658	6,584,831		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,702,587	5,737,691		5.00
7.00	00700	OPERATION OF PLANT	-927	1,406,722		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,192		8.00
9.00	00900	HOUSEKEEPING	0	902,320		9.00
10.00	01000	DIETARY	-1,028	171,356		10.00
11.00	01100	CAFETERIA	-78,213	256,703		11.00
13.00	01300	NURSING ADMINISTRATION	-2,349	219,411		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	241,941		14.00
15.00	01500	PHARMACY	-152,974	5,733,203		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28	234,298		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-943,880	1,036,879		30.00
31.00	03100	INTENSIVE CARE UNIT	-232,333	116,745		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-770,991	1,296,169		50.00
51.00	05100	RECOVERY ROOM	0	251,112		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-740,932	1,196,896		54.00
54.01	05401	ONCOLOGY	0	618,602		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	-3,020	1,988,872		60.00
65.00	06500	RESPIRATORY THERAPY	0	210,687		65.00
66.00	06600	PHYSICAL THERAPY	0	453,226		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	241,947		67.00
68.00	06800	SPEECH PATHOLOGY	0	30,482		68.00
69.00	06900	ELECTROCARDIOLOGY	-39	191,802		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-6,727	1,526,976		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,786,610		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,607		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-169,158	2,006,752		88.00
90.00	09000	CLINIC	-520,378	452,031		90.00
90.01	09001	SURGICAL ASSOCIATES	-614,095	2,499		90.01
90.02	09002	ORTHOPAEDICS	-366,765	304,203		90.02
90.03	09003	RHEUMATOLOGY	0	34,488		90.03
90.04	09004	SPECIALTY CLINIC	-2,310,695	251,443		90.04
90.05	09005	PEDIATRICS	-378,000	115,057		90.05
90.06	09006	WOMEN'S HEALTH	0	34,507		90.06
90.07	09007	PAIN MANAGEMENT	-780,623	-11,674		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	0	2,456,549		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,105	317,703		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,019,373	40,793,409		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	159,718		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
193.03	19303	GUEST MEALS	0	0		193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	256,407		193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,019,373	41,209,534		200.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/26/2024 1:37 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	17,195	0	1.00
2.00	OPERATION OF PLANT	7.00	42,986	0	2.00
3.00	HOUSEKEEPING	9.00	42,986	0	3.00
4.00	DIETARY	10.00	34,389	0	4.00
5.00	RECOVERY ROOM	51.00	228,082	0	5.00
	0		365,638	0	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	267,782	67,134	1.00
	0		267,782	67,134	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,533,703	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,526	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	1,544,229	
	E - RHC & BH RECLASS				
1.00	BEHAVIORAL HEALTH CLINIC	193.04	225,629	30,778	1.00
	TOTALS		225,629	30,778	
	F - ECHO EXPENSE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	0	72,148	1.00
	0		0	72,148	
	G - RECLASS RHC EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	31,960	0	1.00
	0		31,960	0	
	H - THERAPIES RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	248,101	0	1.00
2.00	SPEECH PATHOLOGY	68.00	40,401	0	2.00
	TOTALS		288,502	0	
	I - SPECIALTY RECLASS				
1.00	ORTHOPAEDICS	90.02	256,846	0	1.00
2.00	RHEUMATOLOGY	90.03	63,993	0	2.00
3.00	WOMEN'S HEALTH	90.06	49,615	0	3.00
	TOTALS		370,454	0	
500.00	Grand Total: Increases		1,549,965	1,714,289	500.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/26/2024 1:37 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	137,556	0	0		1.00
2.00	OPERATING ROOM	50.00	228,082	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		365,638	0			
	B - DIETARY/ CAFETERIA						
1.00	DIETARY	10.00	267,782	67,134	0		1.00
	0		267,782	67,134			
	C - MED SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	11,018	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	332	0		3.00
4.00	OPERATING ROOM	50.00	0	792,673	0		4.00
5.00	RECOVERY ROOM	51.00	0	14,970	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,325	0		6.00
7.00	ONCOLOGY	54.01	0	7,028	0		7.00
8.00	LABORATORY	60.00	0	98,381	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	82	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,068	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	79	0		11.00
12.00	SPEECH PATHOLOGY	68.00	0	238	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	356	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,620	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	30,388	0		15.00
16.00	CLINIC	90.00	0	139,954	0		16.00
17.00	SURGICAL ASSOCIATES	90.01	0	220	0		17.00
18.00	ORTHOPAEDICS	90.02	0	3,348	0		18.00
19.00	RHEUMATOLOGY	90.03	0	923	0		19.00
20.00	SPECIALTY CLINIC	90.04	0	372,266	0		20.00
21.00	PEDIATRICS	90.05	0	23,116	0		21.00
22.00	PAIN MANAGEMENT	90.07	0	405	0		22.00
23.00	EMERGENCY	91.00	0	38,152	0		23.00
24.00	AMBULANCE SERVICES	95.00	0	286	0		24.00
	0		0	1,544,229			
	E - RHC & BH RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	225,629	30,778	0		1.00
	TOTALS		225,629	30,778			
	F - ECHO EXPENSE RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	72,148	0		1.00
	0		0	72,148			
	G - RECLASS RHC EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	31,960	0	0		1.00
	0		31,960	0			
	H - THERAPIES RECLASS						
1.00	PHYSICAL THERAPY	66.00	288,502	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		288,502	0			
	I - SPECIALTY RECLASS						
1.00	SPECIALTY CLINIC	90.04	370,454	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		370,454	0			
500.00	Grand Total: Decreases		1,549,965	1,714,289			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	591,263	0	0	0	0	1.00
2.00	Land Improvements	785,101	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,481,510	1,748,802	0	1,748,802	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,250,139	240,558	0	240,558	1,494,410	5.00
6.00	Movable Equipment	21,326,672	1,268,566	0	1,268,566	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,434,685	3,257,926	0	3,257,926	1,494,410	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	51,434,685	3,257,926	0	3,257,926	1,494,410	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	591,263	0	1.00
2.00	Land Improvements	785,101	0	2.00
3.00	Buildings and Fixtures	24,230,312	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,996,287	0	5.00
6.00	Movable Equipment	22,595,238	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,198,201	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	53,198,201	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 4/26/2024 1:37 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,141,436	0	61,428	97,575	0	1.00
3.00	Total (sum of lines 1-2)	2,141,436	0	61,428	97,575	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,300,439		1.00
3.00	Total (sum of lines 1-2)	0	2,300,439		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 4/26/2024 1:37 pm

	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	NEW CAP REL COSTS-BLDG & FIXT	53,198,201	0	53,198,201	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	53,198,201	0	53,198,201	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,140,996	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,140,996	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	97,575	0	0	2,238,571	1.00
3.00	Total (sum of lines 1-2)	0	97,575	0	0	2,238,571	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 4/26/2024 1:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,736,739			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 4/26/2024 1:37 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-440	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA	B	-78,213	CAFETERIA	11.00	0	33.00
33.01	SALE OF PODIATRY SUPPLIES	B	-6,727	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	PHYSICIAN APPLICATION FEES	B	-2,500	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NSF FEES	B	-5,784	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MEDICAL RECORDS TRANSCRIPTIONS FEES	B	-28	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	COPIER FEES	B	-3,969	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ATHLETIC TRAINER - SCHOOL REV	B	-6,017	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OCCUPATIONAL HEALTH	B	-78,021	CLINIC	90.00	0	33.07
33.08	SHUTTLE BUS SERVICES	B	-1,105	AMBULANCE SERVICES	95.00	0	33.08
33.09	MISC. INCOME	B	-90	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	INTEREST INCOME	B	-61,428	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	TELEPHONE SALARY	B	-6,182	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	TELEPHONE OTHER	A	-1,396	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	TELEPHONE BENEFITS	A	-981	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ADVERTISING	A	-174,874	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	IHA & AHA LOBBYING	A	-5,032	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	REBATES	A	-4,268	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	REBATES	B	-927	OPERATION OF PLANT	7.00	0	33.17
33.18	REBATES	B	-1,028	DIETARY	10.00	0	33.18
33.19	REBATES	B	-2,349	NURSING ADMINISTRATION	13.00	0	33.19
33.20	REBATES	B	-152,974	PHARMACY	15.00	0	33.20
33.21	REBATES	B	-122	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	REBATES	B	-6,791	OPERATING ROOM	50.00	0	33.22
33.23	REBATES	B	-2,400	RADIOLOGY-DIAGNOSTIC	54.00	0	33.23
33.24	REBATES	B	-3,020	LABORATORY	60.00	0	33.24
33.25	REBATES	B	-39	ELECTROCARDIOLOGY	69.00	0	33.25
33.26	REBATES	B	-3,700	RURAL HEALTH CLINIC	88.00	0	33.26
33.27	REBATES	B	-77	SPECIALTY CLINIC	90.04	0	33.27
33.28	HAF EXPENSE	B	-3,083,646	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	PHYSICIAN RECRUITMENTS	A	-75,000	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	ADVERTISING	A	-513,506	ADMINISTRATIVE & GENERAL	5.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,019,373				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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 4/26/2024 1:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	943,758	943,758	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	232,333	232,333	0	0	0	2.00
3.00	50.00	OPERATING ROOM	768,249	764,200	4,049	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	752,577	738,532	14,045	0	0	4.00
5.00	54.01	ONCOLOGY	187,800	0	187,800	0	0	5.00
6.00	60.00	LABORATORY	75,000	0	75,000	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	167,686	165,458	2,228	0	0	7.00
8.00	90.00	CLINIC	464,269	442,357	21,912	0	0	8.00
9.00	90.01	SURGICAL ASSOCIATES	615,999	614,095	1,904	0	0	9.00
10.00	90.02	ORTHOPAEDICS	370,485	366,765	3,720	0	0	10.00
11.00	90.04	SPECIALTY CLINIC	2,413,103	2,310,618	102,485	0	0	11.00
12.00	90.05	PEDIATRICS	406,571	378,000	28,571	0	0	12.00
13.00	90.07	PAIN MANAGEMENT	793,540	780,623	12,917	0	0	13.00
14.00	91.00	EMERGENCY	1,474,381	0	1,474,381	0	0	14.00
200.00			9,665,751	7,736,739	1,929,012		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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ONCOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	9.00
10.00	90.02	ORTHOPAEDICS	0	0	0	0	0	10.00
11.00	90.04	SPECIALTY CLINIC	0	0	0	0	0	11.00
12.00	90.05	PEDIATRICS	0	0	0	0	0	12.00
13.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
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	943,758		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	232,333		2.00
3.00	50.00	OPERATING ROOM	0	0	0	764,200		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	738,532		4.00
5.00	54.01	ONCOLOGY	0	0	0	0		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	165,458		7.00
8.00	90.00	CLINIC	0	0	0	442,357		8.00
9.00	90.01	SURGICAL ASSOCIATES	0	0	0	614,095		9.00
10.00	90.02	ORTHOPAEDICS	0	0	0	366,765		10.00
11.00	90.04	SPECIALTY CLINIC	0	0	0	2,310,618		11.00
12.00	90.05	PEDIATRICS	0	0	0	378,000		12.00
13.00	90.07	PAIN MANAGEMENT	0	0	0	780,623		13.00
14.00	91.00	EMERGENCY	0	0	0	0		14.00
200.00			0	0	0	7,736,739		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 4/26/2024 1:37 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					59	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					0.00	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	527.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	97.62	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)	48.81	48.81	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)					51,495	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)					51,495	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)					51,495	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)					97.62	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					76,144	22.00
23.00	Total salary equivalency (see instructions)					76,144	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)					2,880	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)					2,880	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,880	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)					2,880	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 4/26/2024 1:37 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	97.62	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)	76,144		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,880		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)	79,024		63.00
64.00	Total cost of outside supplier services (from your records)	44,165		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	2,880		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,880		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	0		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	0		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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,238,571	2,238,571				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,584,831	80,485	6,665,316			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,737,691	177,902	967,298	6,882,891	6,882,891	5.00
7.00	00700	OPERATION OF PLANT	1,406,722	340,437	147,710	1,894,869	379,944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,192	0	0	99,192	19,889	8.00
9.00	00900	HOUSEKEEPING	902,320	63,381	193,234	1,158,935	232,380	9.00
10.00	01000	DIETARY	171,356	74,423	44,474	290,253	58,199	10.00
11.00	01100	CAFETERIA	256,703	17,858	82,291	356,852	71,553	11.00
13.00	01300	NURSING ADMINISTRATION	219,411	2,355	66,623	288,389	57,825	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	241,941	46,971	50,619	339,531	68,080	14.00
15.00	01500	PHARMACY	5,733,203	35,098	180,435	5,948,736	1,192,781	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	234,298	79,617	59,724	373,639	74,919	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,036,879	118,884	583,108	1,738,871	348,665	30.00
31.00	03100	INTENSIVE CARE UNIT	116,745	40,542	30,751	188,038	37,704	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,296,169	131,916	481,706	1,909,791	382,936	50.00
51.00	05100	RECOVERY ROOM	251,112	11,371	70,091	332,574	66,685	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,196,896	77,705	401,925	1,676,526	336,164	54.00
54.01	05401	ONCOLOGY	618,602	75,003	123,505	817,110	163,840	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,988,872	54,268	270,274	2,313,414	463,867	60.00
65.00	06500	RESPIRATORY THERAPY	210,687	2,703	53,956	267,346	53,606	65.00
66.00	06600	PHYSICAL THERAPY	453,226	33,824	121,201	608,251	121,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,947	20,985	72,918	335,850	67,342	67.00
68.00	06800	SPEECH PATHOLOGY	30,482	3,494	9,240	43,216	8,665	68.00
69.00	06900	ELECTROCARDIOLOGY	191,802	21,178	33,759	246,739	49,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,526,976	0	0	1,526,976	306,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,786,610	0	0	1,786,610	358,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,607	6,313	16,412	79,332	15,907	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,006,752	125,545	626,665	2,758,962	553,205	88.00
90.00	09000	CLINIC	452,031	177,921	288,220	918,172	184,105	90.00
90.01	09001	SURGICAL ASSOCIATES	2,499	31,970	0	34,469	6,911	90.01
90.02	09002	ORTHOPAEDICS	304,203	19,885	77,941	402,029	80,612	90.02
90.03	09003	RHEUMATOLOGY	34,488	43,747	8,935	87,170	17,479	90.03
90.04	09004	SPECIALTY CLINIC	251,443	61,527	779,010	1,091,980	218,955	90.04
90.05	09005	PEDIATRICS	115,057	64,848	148,761	328,666	65,901	90.05
90.06	09006	WOMEN'S HEALTH	34,507	0	8,747	43,254	8,673	90.06
90.07	09007	PAIN MANAGEMENT	-11,674	29,711	194,635	212,672	42,643	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,456,549	77,223	263,258	2,797,030	560,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	317,703	34,866	89,681	442,250	88,676	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,793,409	2,183,956	6,547,107	40,620,585	6,764,799	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	159,718	36,970	48,872	245,560	49,238	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	256,407	17,645	69,337	343,389	68,854	193.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,209,534	2,238,571	6,665,316	41,209,534	6,882,891	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,274,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,081				8.00
9.00	00900	HOUSEKEEPING	87,928	8,358	1,487,601			9.00
10.00	01000	DIETARY	103,247	3,427	70,233	525,359		10.00
11.00	01100	CAFETERIA	24,774	0	16,852	0	470,031	11.00
13.00	01300	NURSING ADMINISTRATION	3,267	0	2,223	0	4,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,162	0	44,326	0	8,338	14.00
15.00	01500	PHARMACY	48,691	0	33,121	0	14,103	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,452	0	75,133	0	11,645	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	164,928	71,436	112,190	474,799	44,146	30.00
31.00	03100	INTENSIVE CARE UNIT	56,244	6,210	38,259	50,560	3,055	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,006	7,794	124,487	0	32,593	50.00
51.00	05100	RECOVERY ROOM	15,775	0	10,731	0	13,437	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,800	5,036	73,330	0	29,882	54.00
54.01	05401	ONCOLOGY	104,051	0	70,779	0	15,228	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	75,286	0	51,212	0	33,442	60.00
65.00	06500	RESPIRATORY THERAPY	3,750	1,003	2,551	0	5,811	65.00
66.00	06600	PHYSICAL THERAPY	46,923	2,344	31,919	0	12,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,113	1,078	19,804	0	7,809	67.00
68.00	06800	SPEECH PATHOLOGY	4,848	46	3,298	0	1,332	68.00
69.00	06900	ELECTROCARDIOLOGY	29,381	0	19,986	0	4,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,758	0	5,957	0	2,159	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	174,168	0	118,475	0	65,598	88.00
90.00	09000	CLINIC	246,826	0	167,902	0	34,522	90.00
90.01	09001	SURGICAL ASSOCIATES	44,352	0	30,170	0	184	90.01
90.02	09002	ORTHOPAEDICS	27,586	0	18,765	0	19,317	90.02
90.03	09003	RHEUMATOLOGY	60,690	0	41,283	0	2,572	90.03
90.04	09004	SPECIALTY CLINIC	85,356	0	58,063	0	29,354	90.04
90.05	09005	PEDIATRICS	89,963	0	61,196	0	11,530	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	2,136	90.06
90.07	09007	PAIN MANAGEMENT	41,219	0	28,038	0	9,004	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	107,131	12,349	72,874	0	27,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	48,370	0	32,903	0	12,518	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,199,045	119,081	1,436,060	525,359	457,788	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	51,289	0	34,889	0	4,640	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	24,479	0	16,652	0	7,603	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,274,813	119,081	1,487,601	525,359	470,031	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	355,884					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	525,437				14.00
15.00	01500	PHARMACY	0	2,219	7,239,651			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	104	0	645,892		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,039	2,960	0	15,293	3,037,327	30.00
31.00	03100	INTENSIVE CARE UNIT	4,421	21	0	1,088	385,600	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,292	38,011	0	66,142	2,792,052	50.00
51.00	05100	RECOVERY ROOM	19,486	2,534	0	15,401	476,623	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,355	5,364	0	159,161	2,436,618	54.00
54.01	05401	ONCOLOGY	22,091	1,972	0	6,167	1,201,238	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	48,519	76,642	0	78,293	3,140,675	60.00
65.00	06500	RESPIRATORY THERAPY	8,414	660	0	2,129	345,270	65.00
66.00	06600	PHYSICAL THERAPY	17,550	1,182	0	13,570	855,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,343	128	0	8,179	480,646	67.00
68.00	06800	SPEECH PATHOLOGY	1,938	29	0	1,395	64,767	68.00
69.00	06900	ELECTROCARDIOLOGY	6,700	1,313	0	21,824	380,034	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	171,753	0	43,139	2,048,045	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	200,039	0	36,333	2,381,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,144	324	7,239,651	108,273	7,463,505	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,930	0	8,490	3,681,828	88.00
90.00	09000	CLINIC	0	3,083	0	3,526	1,558,136	90.00
90.01	09001	SURGICAL ASSOCIATES	0	186	0	136	116,408	90.01
90.02	09002	ORTHOPAEDICS	0	303	0	471	549,083	90.02
90.03	09003	RHEUMATOLOGY	0	183	0	253	209,630	90.03
90.04	09004	SPECIALTY CLINIC	0	2,327	0	936	1,486,971	90.04
90.05	09005	PEDIATRICS	0	576	0	1,122	558,954	90.05
90.06	09006	WOMEN'S HEALTH	0	292	0	79	54,434	90.06
90.07	09007	PAIN MANAGEMENT	0	519	0	377	334,472	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	39,426	9,373	0	49,952	3,676,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	18,166	410	0	4,163	647,456	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,884	525,437	7,239,651	645,892	40,362,941	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	0	385,616	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	0	0	0	460,977	193.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	355,884	525,437	7,239,651	645,892	41,209,534	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,037,327		30.00
31.00	03100	INTENSIVE CARE UNIT	0	385,600		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,792,052		50.00
51.00	05100	RECOVERY ROOM	0	476,623		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,436,618		54.00
54.01	05401	ONCOLOGY	0	1,201,238		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	3,140,675		60.00
65.00	06500	RESPIRATORY THERAPY	0	345,270		65.00
66.00	06600	PHYSICAL THERAPY	0	855,805		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	480,646		67.00
68.00	06800	SPEECH PATHOLOGY	0	64,767		68.00
69.00	06900	ELECTROCARDIOLOGY	0	380,034		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,048,045		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,381,219		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,463,505		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,681,828		88.00
90.00	09000	CLINIC	0	1,558,136		90.00
90.01	09001	SURGICAL ASSOCIATES	0	116,408		90.01
90.02	09002	ORTHOPAEDICS	0	549,083		90.02
90.03	09003	RHEUMATOLOGY	0	209,630		90.03
90.04	09004	SPECIALTY CLINIC	0	1,486,971		90.04
90.05	09005	PEDIATRICS	0	558,954		90.05
90.06	09006	WOMEN'S HEALTH	0	54,434		90.06
90.07	09007	PAIN MANAGEMENT	0	334,472		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	0	3,676,145		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	647,456		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	40,362,941		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	385,616		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
193.03	19303	GUEST MEALS	0	0		193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	460,977		193.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	41,209,534		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	80,485	80,485	80,485		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	177,902	177,902	11,675	189,577	5.00
7.00	00700	OPERATION OF PLANT	0	340,437	340,437	1,784	10,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	548	8.00
9.00	00900	HOUSEKEEPING	0	63,381	63,381	2,333	6,401	9.00
10.00	01000	DIETARY	0	74,423	74,423	537	1,603	10.00
11.00	01100	CAFETERIA	0	17,858	17,858	994	1,971	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,355	2,355	805	1,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,971	46,971	611	1,875	14.00
15.00	01500	PHARMACY	0	35,098	35,098	2,179	32,845	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,617	79,617	721	2,064	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	118,884	118,884	7,042	9,604	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,542	40,542	371	1,039	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	131,916	131,916	5,817	10,548	50.00
51.00	05100	RECOVERY ROOM	0	11,371	11,371	846	1,837	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,705	77,705	4,854	9,259	54.00
54.01	05401	ONCOLOGY	0	75,003	75,003	1,491	4,513	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	54,268	54,268	3,264	12,777	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,703	2,703	652	1,477	65.00
66.00	06600	PHYSICAL THERAPY	0	33,824	33,824	1,464	3,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,985	20,985	881	1,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,494	3,494	112	239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,178	21,178	408	1,363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,313	6,313	198	438	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	125,545	125,545	7,568	15,238	88.00
90.00	09000	CLINIC	0	177,921	177,921	3,481	5,071	90.00
90.01	09001	SURGICAL ASSOCIATES	0	31,970	31,970	0	190	90.01
90.02	09002	ORTHOPAEDICS	0	19,885	19,885	941	2,220	90.02
90.03	09003	RHEUMATOLOGY	0	43,747	43,747	108	481	90.03
90.04	09004	SPECIALTY CLINIC	0	61,527	61,527	9,407	6,031	90.04
90.05	09005	PEDIATRICS	0	64,848	64,848	1,796	1,815	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	106	239	90.06
90.07	09007	PAIN MANAGEMENT	0	29,711	29,711	2,350	1,175	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	77,223	77,223	3,179	15,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	34,866	34,866	1,083	2,443	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,183,956	2,183,956	79,058	186,324	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	36,970	36,970	590	1,356	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	17,645	17,645	837	1,897	193.04
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,238,571	2,238,571	80,485	189,577	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	352,686					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	548				8.00
9.00	00900	HOUSEKEEPING	13,632	38	85,785			9.00
10.00	01000	DIETARY	16,007	16	4,050	96,636		10.00
11.00	01100	CAFETERIA	3,841	0	972	0	25,636	11.00
13.00	01300	NURSING ADMINISTRATION	507	0	128	0	228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,103	0	2,556	0	455	14.00
15.00	01500	PHARMACY	7,549	0	1,910	0	769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,124	0	4,333	0	635	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,570	328	6,470	87,336	2,408	30.00
31.00	03100	INTENSIVE CARE UNIT	8,720	29	2,206	9,300	167	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,373	36	7,179	0	1,778	50.00
51.00	05100	RECOVERY ROOM	2,446	0	619	0	733	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,713	23	4,229	0	1,630	54.00
54.01	05401	ONCOLOGY	16,132	0	4,082	0	831	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	11,672	0	2,953	0	1,824	60.00
65.00	06500	RESPIRATORY THERAPY	581	5	147	0	317	65.00
66.00	06600	PHYSICAL THERAPY	7,275	11	1,841	0	660	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,514	5	1,142	0	426	67.00
68.00	06800	SPEECH PATHOLOGY	752	0	190	0	73	68.00
69.00	06900	ELECTROCARDIOLOGY	4,555	0	1,153	0	252	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,358	0	344	0	118	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,003	0	6,832	0	3,574	88.00
90.00	09000	CLINIC	38,269	0	9,681	0	1,883	90.00
90.01	09001	SURGICAL ASSOCIATES	6,876	0	1,740	0	10	90.01
90.02	09002	ORTHOPAEDICS	4,277	0	1,082	0	1,054	90.02
90.03	09003	RHEUMATOLOGY	9,409	0	2,381	0	140	90.03
90.04	09004	SPECIALTY CLINIC	13,234	0	3,348	0	1,601	90.04
90.05	09005	PEDIATRICS	13,948	0	3,529	0	629	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	117	90.06
90.07	09007	PAIN MANAGEMENT	6,391	0	1,617	0	491	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	16,609	57	4,202	0	1,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,499	0	1,897	0	683	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	340,939	548	82,813	96,636	24,968	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	7,952	0	2,012	0	253	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	3,795	0	960	0	415	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	352,686	548	85,785	96,636	25,636	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,616					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,571				14.00
15.00	01500	PHARMACY	0	264	80,614			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	104,506		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,009	352	0	2,475	261,478	30.00
31.00	03100	INTENSIVE CARE UNIT	70	2	0	176	62,622	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	746	4,527	0	10,704	201,624	50.00
51.00	05100	RECOVERY ROOM	307	302	0	2,492	20,953	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684	639	0	25,734	141,470	54.00
54.01	05401	ONCOLOGY	349	235	0	998	103,634	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	766	9,127	0	12,671	109,322	60.00
65.00	06500	RESPIRATORY THERAPY	133	79	0	345	6,439	65.00
66.00	06600	PHYSICAL THERAPY	277	141	0	2,196	51,048	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	15	0	1,324	31,326	67.00
68.00	06800	SPEECH PATHOLOGY	31	3	0	226	5,120	68.00
69.00	06900	ELECTROCARDIOLOGY	106	156	0	3,532	32,703	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,453	0	6,981	35,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	23,821	0	5,880	39,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50	39	80,614	17,522	106,994	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	349	0	1,374	187,483	88.00
90.00	09000	CLINIC	0	367	0	571	237,244	90.00
90.01	09001	SURGICAL ASSOCIATES	0	22	0	22	40,830	90.01
90.02	09002	ORTHOPAEDICS	0	36	0	76	29,571	90.02
90.03	09003	RHEUMATOLOGY	0	22	0	41	56,329	90.03
90.04	09004	SPECIALTY CLINIC	0	277	0	152	95,577	90.04
90.05	09005	PEDIATRICS	0	69	0	182	86,816	90.05
90.06	09006	WOMEN'S HEALTH	0	35	0	13	510	90.06
90.07	09007	PAIN MANAGEMENT	0	62	0	61	41,858	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	622	1,116	0	8,084	128,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	287	49	0	674	49,481	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,616	62,571	80,614	104,506	2,163,889	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	0	49,133	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	0	0	0	25,549	193.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,616	62,571	80,614	104,506	2,238,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	261,478		30.00
31.00	03100	INTENSIVE CARE UNIT	0	62,622		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	201,624		50.00
51.00	05100	RECOVERY ROOM	0	20,953		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	141,470		54.00
54.01	05401	ONCOLOGY	0	103,634		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	109,322		60.00
65.00	06500	RESPIRATORY THERAPY	0	6,439		65.00
66.00	06600	PHYSICAL THERAPY	0	51,048		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,326		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,120		68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,703		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,867		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	39,568		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,994		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	187,483		88.00
90.00	09000	CLINIC	0	237,244		90.00
90.01	09001	SURGICAL ASSOCIATES	0	40,830		90.01
90.02	09002	ORTHOPAEDICS	0	29,571		90.02
90.03	09003	RHEUMATOLOGY	0	56,329		90.03
90.04	09004	SPECIALTY CLINIC	0	95,577		90.04
90.05	09005	PEDIATRICS	0	86,816		90.05
90.06	09006	WOMEN'S HEALTH	0	510		90.06
90.07	09007	PAIN MANAGEMENT	0	41,858		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	0	128,022		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	49,481		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,163,889		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	49,133		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
193.03	19303	GUEST MEALS	0	0		193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	25,549		193.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,238,571		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	115,954					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,169	21,689,503				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,215	3,147,656	-6,882,891	34,326,643		5.00
7.00	00700	OPERATION OF PLANT	17,634	480,661	0	1,894,869	84,936	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	99,192	0	8.00
9.00	00900	HOUSEKEEPING	3,283	628,799	0	1,158,935	3,283	9.00
10.00	01000	DIETARY	3,855	144,723	0	290,253	3,855	10.00
11.00	01100	CAFETERIA	925	267,782	0	356,852	925	11.00
13.00	01300	NURSING ADMINISTRATION	122	216,796	0	288,389	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,433	164,718	0	339,531	2,433	14.00
15.00	01500	PHARMACY	1,818	587,151	0	5,948,736	1,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,124	194,348	0	373,639	4,124	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,158	1,897,482	0	1,738,871	6,158	30.00
31.00	03100	INTENSIVE CARE UNIT	2,100	100,068	0	188,038	2,100	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,833	1,567,514	0	1,909,791	6,833	50.00
51.00	05100	RECOVERY ROOM	589	228,082	0	332,574	589	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,025	1,307,899	0	1,676,526	4,025	54.00
54.01	05401	ONCOLOGY	3,885	401,896	0	817,110	3,885	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,811	879,496	0	2,313,414	2,811	60.00
65.00	06500	RESPIRATORY THERAPY	140	175,579	0	267,346	140	65.00
66.00	06600	PHYSICAL THERAPY	1,752	394,400	0	608,251	1,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,087	237,282	0	335,850	1,087	67.00
68.00	06800	SPEECH PATHOLOGY	181	30,068	0	43,216	181	68.00
69.00	06900	ELECTROCARDIOLOGY	1,097	109,855	0	246,739	1,097	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,526,976	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,786,610	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327	53,407	0	79,332	327	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,503	2,039,222	0	2,758,962	6,503	88.00
90.00	09000	CLINIC	9,216	937,891	0	918,172	9,216	90.00
90.01	09001	SURGICAL ASSOCIATES	1,656	0	0	34,469	1,656	90.01
90.02	09002	ORTHOPAEDICS	1,030	253,626	0	402,029	1,030	90.02
90.03	09003	RHEUMATOLOGY	2,266	29,076	0	87,170	2,266	90.03
90.04	09004	SPECIALTY CLINIC	3,187	2,534,965	0	1,091,980	3,187	90.04
90.05	09005	PEDIATRICS	3,359	484,081	0	328,666	3,359	90.05
90.06	09006	WOMEN'S HEALTH	0	28,465	0	43,254	0	90.06
90.07	09007	PAIN MANAGEMENT	1,539	633,360	0	212,672	1,539	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	4,000	856,663	0	2,797,030	4,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,806	291,830	0	442,250	1,806	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,125	21,304,841	-6,882,891	33,737,694	82,107	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	1,915	159,033	0	245,560	1,915	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	914	225,629	0	343,389	914	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,238,571	6,665,316		6,882,891	2,274,813	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.305682	0.307306		0.200512	26.782672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		80,485		189,577	352,686	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003711		0.005523	4.152374	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/26/2024 1:37 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	81,653				9.00
10.00	01000	DIETARY	820	3,855	2,712			10.00
11.00	01100	CAFETERIA	0	925	0	20,464		11.00
13.00	01300	NURSING ADMINISTRATION	0	122	0	182	222,174	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,433	0	363	0	14.00
15.00	01500	PHARMACY	0	1,818	0	614	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,124	0	507	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,094	6,158	2,451	1,922	39,978	30.00
31.00	03100	INTENSIVE CARE UNIT	1,486	2,100	261	133	2,760	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	6,833	0	1,419	29,524	50.00
51.00	05100	RECOVERY ROOM	0	589	0	585	12,165	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	4,025	0	1,301	27,066	54.00
54.01	05401	ONCOLOGY	0	3,885	0	663	13,791	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,811	0	1,456	30,290	60.00
65.00	06500	RESPIRATORY THERAPY	240	140	0	253	5,253	65.00
66.00	06600	PHYSICAL THERAPY	561	1,752	0	527	10,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	1,087	0	340	7,081	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	58	1,210	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,097	0	201	4,183	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327	0	94	1,963	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,503	0	2,856	0	88.00
90.00	09000	CLINIC	0	9,216	0	1,503	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,656	0	8	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,030	0	841	0	90.02
90.03	09003	RHEUMATOLOGY	0	2,266	0	112	0	90.03
90.04	09004	SPECIALTY CLINIC	0	3,187	0	1,278	0	90.04
90.05	09005	PEDIATRICS	0	3,359	0	502	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	93	0	90.06
90.07	09007	PAIN MANAGEMENT	0	1,539	0	392	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,955	4,000	0	1,183	24,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,806	0	545	11,341	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	78,824	2,712	19,931	222,174	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	1,915	0	202	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	914	0	331	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	119,081	1,487,601	525,359	470,031	355,884	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.179014	18.218571	193.716445	22.968677	1.601826	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	548	85,785	96,636	25,636	5,616	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019231	1.050604	35.632743	1.252737	0.025277	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/26/2024 1:37 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,692,007				14.00
15.00	01500	PHARMACY	19,811	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	933	0	130,019,726		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	26,428	0	3,078,271		30.00
31.00	03100	INTENSIVE CARE UNIT	186	0	219,067		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	339,430	0	13,313,680		50.00
51.00	05100	RECOVERY ROOM	22,624	0	3,100,102		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,901	0	32,046,308		54.00
54.01	05401	ONCOLOGY	17,609	0	1,241,408		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	06000	LABORATORY	684,390	0	15,759,455		60.00
65.00	06500	RESPIRATORY THERAPY	5,891	0	428,576		65.00
66.00	06600	PHYSICAL THERAPY	10,559	0	2,731,448		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,140	0	1,646,300		67.00
68.00	06800	SPEECH PATHOLOGY	257	0	280,867		68.00
69.00	06900	ELECTROCARDIOLOGY	11,724	0	4,392,970		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,533,703	0	8,683,338		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,786,305	0	7,313,338		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,896	100	21,794,062		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	26,163	0	1,708,886		88.00
90.00	09000	CLINIC	27,532	0	709,785		90.00
90.01	09001	SURGICAL ASSOCIATES	1,661	0	27,358		90.01
90.02	09002	ORTHOPAEDICS	2,708	0	94,787		90.02
90.03	09003	RHEUMATOLOGY	1,638	0	50,997		90.03
90.04	09004	SPECIALTY CLINIC	20,783	0	188,475		90.04
90.05	09005	PEDIATRICS	5,140	0	225,754		90.05
90.06	09006	WOMEN'S HEALTH	2,605	0	15,811		90.06
90.07	09007	PAIN MANAGEMENT	4,633	0	75,842		90.07
90.08	09008	ONCOLOGY MD	0	0	0		90.08
91.00	09100	EMERGENCY	83,695	0	10,054,828		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	3,662	0	838,013		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,692,007	100	130,019,726		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	FOUNDATION	0	0	0		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0		193.02
193.03	19303	GUEST MEALS	0	0	0		193.03
193.04	19304	BEHAVIORAL HEALTH CLINIC	0	0	0		193.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	525,437	7,239,651	645,892		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.111986	72,396.510000	0.004968		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,571	80,614	104,506		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013336	806.140000	0.000804		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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,037,327		3,037,327	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	385,600		385,600	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,792,052		2,792,052	0	0	50.00
51.00	05100	RECOVERY ROOM	476,623		476,623	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,436,618		2,436,618	0	0	54.00
54.01	05401	ONCOLOGY	1,201,238		1,201,238	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,140,675		3,140,675	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	345,270	0	345,270	0	0	65.00
66.00	06600	PHYSICAL THERAPY	855,805	0	855,805	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,646	0	480,646	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,767	0	64,767	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	380,034		380,034	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,048,045		2,048,045	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,381,219		2,381,219	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,463,505		7,463,505	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,681,828		3,681,828	0	0	88.00
90.00	09000	CLINIC	1,558,136		1,558,136	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	116,408		116,408	0	0	90.01
90.02	09002	ORTHOPAEDICS	549,083		549,083	0	0	90.02
90.03	09003	RHEUMATOLOGY	209,630		209,630	0	0	90.03
90.04	09004	SPECIALTY CLINIC	1,486,971		1,486,971	0	0	90.04
90.05	09005	PEDIATRICS	558,954		558,954	0	0	90.05
90.06	09006	WOMEN'S HEALTH	54,434		54,434	0	0	90.06
90.07	09007	PAIN MANAGEMENT	334,472		334,472	0	0	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,676,145		3,676,145	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,157		1,341,157		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	647,456		647,456	0	0	95.00
200.00		Subtotal (see instructions)	41,704,098	0	41,704,098	0	0	200.00
201.00		Less Observation Beds	1,341,157		1,341,157		0	201.00
202.00		Total (see instructions)	40,362,941	0	40,362,941	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,717,193		1,717,193			30.00
31.00	03100	INTENSIVE CARE UNIT	219,067		219,067			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	288,970	13,024,710	13,313,680	0.209713	0.000000	50.00
51.00	05100	RECOVERY ROOM	76,286	3,023,816	3,100,102	0.153744	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,936	31,366,372	32,046,308	0.076034	0.000000	54.00
54.01	05401	ONCOLOGY	0	1,241,408	1,241,408	0.967642	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	850,000	14,909,455	15,759,455	0.199288	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	185,961	242,615	428,576	0.805621	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	128,313	2,603,135	2,731,448	0.313316	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,814	1,521,486	1,646,300	0.291955	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,505	258,362	280,867	0.230597	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	309,587	4,083,383	4,392,970	0.086510	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,565	8,445,773	8,683,338	0.235859	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	87,149	7,226,189	7,313,338	0.325599	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674,709	21,119,353	21,794,062	0.342456	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,708,886	1,708,886			88.00
90.00	09000	CLINIC	0	709,785	709,785	2.195222	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	27,358	27,358	4.254989	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	94,787	94,787	5.792809	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	50,997	50,997	4.110634	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	188,475	188,475	7.889487	0.000000	90.04
90.05	09005	PEDIATRICS	0	225,754	225,754	2.475943	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	15,811	15,811	3.442793	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	75,842	75,842	4.410116	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	152,840	9,901,988	10,054,828	0.365610	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,137	1,355,941	1,361,078	0.985364	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	838,013	838,013	0.772609	0.000000	95.00
200.00		Subtotal (see instructions)	5,760,032	124,259,694	130,019,726			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,760,032	124,259,694	130,019,726			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	ONCOLOGY	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	SPECIALTY CLINIC	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
90.08	09008	ONCOLOGY MD	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,037,327		3,037,327	0	3,037,327	30.00
31.00	03100	INTENSIVE CARE UNIT	385,600		385,600	0	385,600	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,792,052		2,792,052	0	2,792,052	50.00
51.00	05100	RECOVERY ROOM	476,623		476,623	0	476,623	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,436,618		2,436,618	0	2,436,618	54.00
54.01	05401	ONCOLOGY	1,201,238		1,201,238	0	1,201,238	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,140,675		3,140,675	0	3,140,675	60.00
65.00	06500	RESPIRATORY THERAPY	345,270	0	345,270	0	345,270	65.00
66.00	06600	PHYSICAL THERAPY	855,805	0	855,805	0	855,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,646	0	480,646	0	480,646	67.00
68.00	06800	SPEECH PATHOLOGY	64,767	0	64,767	0	64,767	68.00
69.00	06900	ELECTROCARDIOLOGY	380,034		380,034	0	380,034	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,048,045		2,048,045	0	2,048,045	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,381,219		2,381,219	0	2,381,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,463,505		7,463,505	0	7,463,505	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,681,828		3,681,828	0	3,681,828	88.00
90.00	09000	CLINIC	1,558,136		1,558,136	0	1,558,136	90.00
90.01	09001	SURGICAL ASSOCIATES	116,408		116,408	0	116,408	90.01
90.02	09002	ORTHOPAEDICS	549,083		549,083	0	549,083	90.02
90.03	09003	RHEUMATOLOGY	209,630		209,630	0	209,630	90.03
90.04	09004	SPECIALTY CLINIC	1,486,971		1,486,971	0	1,486,971	90.04
90.05	09005	PEDIATRICS	558,954		558,954	0	558,954	90.05
90.06	09006	WOMEN'S HEALTH	54,434		54,434	0	54,434	90.06
90.07	09007	PAIN MANAGEMENT	334,472		334,472	0	334,472	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	3,676,145		3,676,145	0	3,676,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,157		1,341,157		1,341,157	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	647,456		647,456	0	647,456	95.00
200.00		Subtotal (see instructions)	41,704,098	0	41,704,098	0	41,704,098	200.00
201.00		Less Observation Beds	1,341,157		1,341,157		1,341,157	201.00
202.00		Total (see instructions)	40,362,941	0	40,362,941	0	40,362,941	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,717,193		1,717,193			30.00
31.00	03100	INTENSIVE CARE UNIT	219,067		219,067			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	288,970	13,024,710	13,313,680	0.209713	0.000000	50.00
51.00	05100	RECOVERY ROOM	76,286	3,023,816	3,100,102	0.153744	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,936	31,366,372	32,046,308	0.076034	0.000000	54.00
54.01	05401	ONCOLOGY	0	1,241,408	1,241,408	0.967642	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	850,000	14,909,455	15,759,455	0.199288	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	185,961	242,615	428,576	0.805621	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	128,313	2,603,135	2,731,448	0.313316	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,814	1,521,486	1,646,300	0.291955	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,505	258,362	280,867	0.230597	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	309,587	4,083,383	4,392,970	0.086510	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,565	8,445,773	8,683,338	0.235859	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	87,149	7,226,189	7,313,338	0.325599	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674,709	21,119,353	21,794,062	0.342456	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,708,886	1,708,886	2.154519	0.000000	88.00
90.00	09000	CLINIC	0	709,785	709,785	2.195222	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	27,358	27,358	4.254989	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	94,787	94,787	5.792809	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	50,997	50,997	4.110634	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	188,475	188,475	7.889487	0.000000	90.04
90.05	09005	PEDIATRICS	0	225,754	225,754	2.475943	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	15,811	15,811	3.442793	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	75,842	75,842	4.410116	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	152,840	9,901,988	10,054,828	0.365610	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,137	1,355,941	1,361,078	0.985364	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	838,013	838,013	0.772609	0.000000	95.00
200.00		Subtotal (see instructions)	5,760,032	124,259,694	130,019,726			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,760,032	124,259,694	130,019,726			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	ONCOLOGY	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	SPECIALTY CLINIC	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
90.08	09008	ONCOLOGY MD	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,624	13,313,680	0.015144	96,831	1,466	50.00
51.00	05100	RECOVERY ROOM	20,953	3,100,102	0.006759	21,006	142	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,470	32,046,308	0.004415	265,313	1,171	54.00
54.01	05401	ONCOLOGY	103,634	1,241,408	0.083481	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	109,322	15,759,455	0.006937	336,773	2,336	60.00
65.00	06500	RESPIRATORY THERAPY	6,439	428,576	0.015024	63,437	953	65.00
66.00	06600	PHYSICAL THERAPY	51,048	2,731,448	0.018689	64,949	1,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,326	1,646,300	0.019028	61,512	1,170	67.00
68.00	06800	SPEECH PATHOLOGY	5,120	280,867	0.018229	10,397	190	68.00
69.00	06900	ELECTROCARDIOLOGY	32,703	4,392,970	0.007444	132,262	985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,867	8,683,338	0.004131	22,116	91	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,568	7,313,338	0.005410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,994	21,794,062	0.004909	269,567	1,323	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,483	1,708,886	0.109711	0	0	88.00
90.00	09000	CLINIC	237,244	709,785	0.334248	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	40,830	27,358	1.492434	0	0	90.01
90.02	09002	ORTHOPAEDICS	29,571	94,787	0.311973	0	0	90.02
90.03	09003	RHEUMATOLOGY	56,329	50,997	1.104555	0	0	90.03
90.04	09004	SPECIALTY CLINIC	95,577	188,475	0.507107	0	0	90.04
90.05	09005	PEDIATRICS	86,816	225,754	0.384560	0	0	90.05
90.06	09006	WOMEN'S HEALTH	510	15,811	0.032256	0	0	90.06
90.07	09007	PAIN MANAGEMENT	41,858	75,842	0.551911	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	128,022	10,054,828	0.012732	1,540	20	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,458	1,361,078	0.084828	4,575	388	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,905,766	127,245,453		1,350,278	11,449	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,313,680	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,100,102	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,046,308	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	1,241,408	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	15,759,455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	428,576	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,731,448	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,646,300	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	280,867	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,392,970	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,683,338	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,313,338	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,794,062	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,708,886	0.000000	88.00
90.00	09000	CLINIC	0	0	0	709,785	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	27,358	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	94,787	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	50,997	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	188,475	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	225,754	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	15,811	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	75,842	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	10,054,828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,361,078	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	127,245,453		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	96,831	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	21,006	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	265,313	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	336,773	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	63,437	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	64,949	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	61,512	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,397	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	132,262	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,116	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	269,567	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	1,540	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,575	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,350,278	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.209713	0	3,125,778	0	0	50.00
51.00	05100	RECOVERY ROOM	0.153744	0	579,521	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076034	0	6,405,407	0	0	54.00
54.01	05401	ONCOLOGY	0.967642	0	349,244	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.199288	0	3,340,837	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.805621	0	32,832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.313316	0	892,252	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291955	0	396,880	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.230597	0	31,423	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086510	0	1,251,278	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235859	0	1,926,262	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.325599	0	2,870,990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342456	0	9,283,039	4,675	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.195222	0	34,980	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	4.254989	0	7,002	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.792809	0	55,281	0	0	90.02
90.03	09003	RHEUMATOLOGY	4.110634	0	30,499	0	0	90.03
90.04	09004	SPECIALTY CLINIC	7.889487	0	98,310	0	0	90.04
90.05	09005	PEDIATRICS	2.475943	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.442793	0	1,315	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.410116	0	19,320	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.365610	0	1,364,187	898	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.985364	0	257,323	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.772609		0			95.00
200.00		Subtotal (see instructions)		0	32,353,960	5,573	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	32,353,960	5,573	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	655,516	0		50.00
51.00	05100	RECOVERY ROOM	89,098	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,029	0		54.00
54.01	05401	ONCOLOGY	337,943	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	665,789	0		60.00
65.00	06500	RESPIRATORY THERAPY	26,450	0		65.00
66.00	06600	PHYSICAL THERAPY	279,557	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	115,871	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,246	0		68.00
69.00	06900	ELECTROCARDIOLOGY	108,248	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,326	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	934,791	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,179,032	1,601		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	76,789	0		90.00
90.01	09001	SURGICAL ASSOCIATES	29,793	0		90.01
90.02	09002	ORTHOPAEDICS	320,232	0		90.02
90.03	09003	RHEUMATOLOGY	125,370	0		90.03
90.04	09004	SPECIALTY CLINIC	775,615	0		90.04
90.05	09005	PEDIATRICS	0	0		90.05
90.06	09006	WOMEN'S HEALTH	4,527	0		90.06
90.07	09007	PAIN MANAGEMENT	85,203	0		90.07
90.08	09008	ONCOLOGY MD	0	0		90.08
91.00	09100	EMERGENCY	498,760	328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	253,557	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	9,510,742	1,929		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,510,742	1,929		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	261,478	7,301	254,177	1,497	169.79	30.00
31.00	INTENSIVE CARE UNIT	62,622		62,622	87	719.79	31.00
200.00	Total (lines 30 through 199)	324,100		316,799	1,584		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	21	3,566	30.00
31.00	INTENSIVE CARE UNIT	1	720	31.00
200.00	Total (lines 30 through 199)	22	4,286	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | 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	201,624	13,313,680	0.015144	32,995	500	50.00
51.00	05100	RECOVERY ROOM	20,953	3,100,102	0.006759	6,912	47	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,470	32,046,308	0.004415	37,392	165	54.00
54.01	05401	ONCOLOGY	103,634	1,241,408	0.083481	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	109,322	15,759,455	0.006937	31,282	217	60.00
65.00	06500	RESPIRATORY THERAPY	6,439	428,576	0.015024	1,417	21	65.00
66.00	06600	PHYSICAL THERAPY	51,048	2,731,448	0.018689	353	7	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,326	1,646,300	0.019028	471	9	67.00
68.00	06800	SPEECH PATHOLOGY	5,120	280,867	0.018229	668	12	68.00
69.00	06900	ELECTROCARDIOLOGY	32,703	4,392,970	0.007444	903	7	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,867	8,683,338	0.004131	6,618	27	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,568	7,313,338	0.005410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,994	21,794,062	0.004909	21,589	106	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,483	1,708,886	0.109711	0	0	88.00
90.00	09000	CLINIC	237,244	709,785	0.334248	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	40,830	27,358	1.492434	0	0	90.01
90.02	09002	ORTHOPAEDICS	29,571	94,787	0.311973	0	0	90.02
90.03	09003	RHEUMATOLOGY	56,329	50,997	1.104555	0	0	90.03
90.04	09004	SPECIALTY CLINIC	95,577	188,475	0.507107	0	0	90.04
90.05	09005	PEDIATRICS	86,816	225,754	0.384560	0	0	90.05
90.06	09006	WOMEN'S HEALTH	510	15,811	0.032256	0	0	90.06
90.07	09007	PAIN MANAGEMENT	41,858	75,842	0.551911	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	128,022	10,054,828	0.012732	13,230	168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,458	1,361,078	0.084828	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,905,766	127,245,453		153,830	1,286	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,497	0.00	21	30.00
31.00	03100	INTENSIVE CARE UNIT		0	87	0.00	1	31.00
200.00		Total (lines 30 through 199)		0	1,584		22	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | 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	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,313,680	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,100,102	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,046,308	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	1,241,408	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	15,759,455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	428,576	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,731,448	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,646,300	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	280,867	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,392,970	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,683,338	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,313,338	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,794,062	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,708,886	0.000000	88.00
90.00	09000	CLINIC	0	0	0	709,785	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	27,358	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	94,787	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	50,997	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	188,475	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	225,754	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	15,811	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	75,842	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	10,054,828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,361,078	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	127,245,453		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | 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	32,995	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	6,912	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	37,392	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	31,282	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,417	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	353	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	471	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	668	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	903	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,618	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	21,589	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	13,230	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		153,830	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,497	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)	817	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	43	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)	404	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)	43	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,037,327	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)	84,808	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,952,519	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)	2,952,519	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,972.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	796,805	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)	796,805	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	385,600	87	4,432.18	23	101,940	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)	316,682	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)	1,215,427	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)	84,808	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	84,808	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)	680	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,972.29	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/26/2024 1:37 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,341,157	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	261,478	3,037,327	0.086088	1,341,157	115,458	90.00
91.00	Nursing Program cost	0	3,037,327	0.000000	1,341,157	0	91.00
92.00	Allied health cost	0	3,037,327	0.000000	1,341,157	0	92.00
93.00	All other Medical Education	0	3,037,327	0.000000	1,341,157	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,497	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)	817	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	43	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)	21	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,037,327	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)	84,808	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,952,519	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)	2,952,519	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,972.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	41,418	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)	41,418	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	385,600	87	4,432.18	1	4,432	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)	32,473	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)	78,323	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)	680	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,972.29	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/26/2024 1:37 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,341,157	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	261,478	3,037,327	0.086088	1,341,157	115,458	90.00
91.00	Nursing Program cost	0	3,037,327	0.000000	1,341,157	0	91.00
92.00	Allied health cost	0	3,037,327	0.000000	1,341,157	0	92.00
93.00	All other Medical Education	0	3,037,327	0.000000	1,341,157	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		811,731		30.00
31.00	03100	INTENSIVE CARE UNIT		69,980		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209713	96,831	20,307	50.00
51.00	05100	RECOVERY ROOM	0.153744	21,006	3,230	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076034	265,313	20,173	54.00
54.01	05401	ONCOLOGY	0.967642	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.199288	336,773	67,115	60.00
65.00	06500	RESPIRATORY THERAPY	0.805621	63,437	51,106	65.00
66.00	06600	PHYSICAL THERAPY	0.313316	64,949	20,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291955	61,512	17,959	67.00
68.00	06800	SPEECH PATHOLOGY	0.230597	10,397	2,398	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086510	132,262	11,442	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235859	22,116	5,216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.325599	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342456	269,567	92,315	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.195222	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	4.254989	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.792809	0	0	90.02
90.03	09003	RHEUMATOLOGY	4.110634	0	0	90.03
90.04	09004	SPECIALTY CLINIC	7.889487	0	0	90.04
90.05	09005	PEDIATRICS	2.475943	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.442793	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.410116	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.365610	1,540	563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.985364	4,575	4,508	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,350,278	316,682	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)		1,350,278		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209713	0	0	50.00
51.00	05100	RECOVERY ROOM	0.153744	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076034	2,025	154	54.00
54.01	05401	ONCOLOGY	0.967642	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.199288	8,567	1,707	60.00
65.00	06500	RESPIRATORY THERAPY	0.805621	201	162	65.00
66.00	06600	PHYSICAL THERAPY	0.313316	16,432	5,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291955	19,094	5,575	67.00
68.00	06800	SPEECH PATHOLOGY	0.230597	2,661	614	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086510	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235859	243	57	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.325599	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342456	10,847	3,715	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.195222	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	4.254989	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.792809	0	0	90.02
90.03	09003	RHEUMATOLOGY	4.110634	0	0	90.03
90.04	09004	SPECIALTY CLINIC	7.889487	0	0	90.04
90.05	09005	PEDIATRICS	2.475943	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.442793	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.410116	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.365610	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.985364	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		60,070	17,132	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)		60,070		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		39,696		30.00
31.00	03100	INTENSIVE CARE UNIT		1,119		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209713	32,995	6,919	50.00
51.00	05100	RECOVERY ROOM	0.153744	6,912	1,063	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076034	37,392	2,843	54.00
54.01	05401	ONCOLOGY	0.967642	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.199288	31,282	6,234	60.00
65.00	06500	RESPIRATORY THERAPY	0.805621	1,417	1,142	65.00
66.00	06600	PHYSICAL THERAPY	0.313316	353	111	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.291955	471	138	67.00
68.00	06800	SPEECH PATHOLOGY	0.230597	668	154	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086510	903	78	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235859	6,618	1,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.325599	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342456	21,589	7,393	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.154519	0	0	88.00
90.00	09000	CLINIC	2.195222	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	4.254989	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.792809	0	0	90.02
90.03	09003	RHEUMATOLOGY	4.110634	0	0	90.03
90.04	09004	SPECIALTY CLINIC	7.889487	0	0	90.04
90.05	09005	PEDIATRICS	2.475943	0	0	90.05
90.06	09006	WOMEN'S HEALTH	3.442793	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.410116	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.365610	13,230	4,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.985364	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		153,830	32,473	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)		153,830		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,512,671	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)	9,512,671	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)	9,607,798	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)	50,833	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,727,673	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)	3,829,292	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)	3,829,292	30.00
31.00	Primary payer payments	889	31.00
32.00	Subtotal (line 30 minus line 31)	3,828,403	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)	556,864	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	361,962	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	357,750	36.00
37.00	Subtotal (see instructions)	4,190,365	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,190,365	40.00
40.01	Sequestration adjustment (see instructions)	83,807	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,489,356	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)	-382,798	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: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/26/2024 1:37 pm
	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		967,093		4,489,356	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)		967,093		4,489,356	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		67,103		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		382,798	6.02
7.00	Total Medicare program liability (see instructions)		1,034,196		4,106,558	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		91,075		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)		91,075		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		9,825		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		100,900		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 4/26/2024 1:37 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	85,656	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)	17,303	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	43	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)	102,959	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	102,959	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)	102,959	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)	102,959	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)	102,959	0	19.00
19.01	Sequestration adjustment (see instructions)	2,059	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	91,075	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)	9,825	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: 15-1304	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 4/26/2024 1:37 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,215,427	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)	1,215,427	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,227,581	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)	1,227,581	19.00
20.00	Deductibles (exclude professional component)	177,564	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,050,017	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,050,017	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,131	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,285	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	110	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,055,302	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)	1,055,302	30.00
30.01	Sequestration adjustment (see instructions)	21,106	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	967,093	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)	67,103	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 4/26/2024 1:37 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	78,323		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)	78,323	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)	78,323	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	40,815		8.00
9.00	Ancillary service charges	153,830	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)	194,645	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)	194,645	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	116,322	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)	78,323	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)	78,323	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)	78,323	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)	78,323	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	78,323	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)	78,323	0	40.00
41.00	Interim payments	82,127	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-3,804	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: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 4/26/2024 1:37 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	11,394,757	0	0	0	1.00
2.00	Temporary investments	2,990,252	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,946,388	0	0	0	4.00
5.00	Other receivable	1,486,446	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-16,671,998	0	0	0	6.00
7.00	Inventory	1,353,076	0	0	0	7.00
8.00	Prepaid expenses	633,753	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)	26,132,674	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	591,263	0	0	0	12.00
13.00	Land improvements	785,101	0	0	0	13.00
14.00	Accumulated depreciation	-770,448	0	0	0	14.00
15.00	Buildings	24,230,312	0	0	0	15.00
16.00	Accumulated depreciation	-6,286,379	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	4,996,287	0	0	0	19.00
20.00	Accumulated depreciation	-1,229,997	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	22,595,238	0	0	0	23.00
24.00	Accumulated depreciation	-22,950,697	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)	21,960,680	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,093,354	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,538,747	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,909,540	0	0	0	38.00
39.00	Payroll taxes payable	1,232,896	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,284,149	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	18,159,604	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,124,936	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,124,936	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,968,421				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)	22,968,421	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,093,357	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 4/26/2024 1:37 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,670,699		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,702,278				2.00
3.00	Total (sum of line 1 and line 2)		22,968,421		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,968,421		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)		22,968,421		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/26/2024 1:37 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,895,685		1,895,685	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	19,773		19,773	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)	1,915,458		1,915,458	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	219,329		219,329	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)	219,329		219,329	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,134,787		2,134,787	17.00
18.00	Ancillary services	3,435,393	120,661,145	124,096,538	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,950,390	2,950,390	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	838,013	838,013	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	572,739	13,699,585	14,272,324	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,142,919	138,149,133	144,292,052	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,228,907		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		53,228,907		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 4/26/2024 1:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,292,052	1.00
2.00	Less contractual allowances and discounts on patients' accounts	93,909,022	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,383,030	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	53,228,907	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,845,877	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	330,073	6.00
7.00	Income from investments	615,639	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	177,695	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	78,213	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	6,727	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	257,397	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	106,679	24.00
24.01	NON-OPERATING INCOME	-932,827	24.01
24.02	CONTRACT PHARMACY	382,878	24.02
24.50	COVID-19 PHE Funding	121,125	24.50
25.00	Total other income (sum of lines 6-24)	1,143,599	25.00
26.00	Total (line 5 plus line 25)	-1,702,278	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)	-1,702,278	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304
Component CCN: 15-8539

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

Worksheet M-1
Date/Time Prepared: 4/26/2024 1:37 pm

RHC I

Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	431,363	0	431,363	0	431,363	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	645,477	0	645,477	31,960	677,437	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	98,213	0	98,213	0	98,213	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	560,688	0	560,688	0	560,688	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,735,741	0	1,735,741	31,960	1,767,701	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	42,468	42,468	-30,387	12,081	15.00
16.00	Transportation (Health Care Staff)	0	2,088	2,088	0	2,088	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44,556	44,556	-30,387	14,169	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,735,741	44,556	1,780,297	1,573	1,781,870	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	39,409	39,409	0	39,409	29.00
30.00	Administrative Costs	271,520	113,889	385,409	-30,778	354,631	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	271,520	153,298	424,818	-30,778	394,040	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,007,261	197,854	2,205,115	-29,205	2,175,910	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 4/26/2024 1:37 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-165,458	265,905		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	677,437		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	98,213		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	560,688		9.00
10.00	Subtotal (sum of lines 1 through 9)	-165,458	1,602,243		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	-3,700	8,381		15.00
16.00	Transportation (Health Care Staff)	0	2,088		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)	-3,700	10,469		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-169,158	1,612,712		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	39,409		29.00
30.00	Administrative Costs	0	354,631		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	394,040		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-169,158	2,006,752		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 4/26/2024 1:37 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.60	3,101	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	5.87	6,577	1	6		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.47	9,678		8	9,678	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	1.44	1,039			1,039	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)	8.91	10,717			10,717	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)	1,612,712	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,612,712	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	394,040	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,675,076	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,069,116	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,069,116	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,069,116	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,681,828	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 4/26/2024 1:37 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,681,828	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		279,587	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,402,241	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,717	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)		10,717	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		317.46	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	174.33	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	174.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,653	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	462,497	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	39	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	6,799	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	6,799	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	469,296	16.00
16.01	Total program charges (see instructions)(from contractor's records)		384,704	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		76,975	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		93,901	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.)		259,482	16.04
16.05	Total program cost (see instructions)	0	353,383	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		51,042	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,146	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		353,383	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		159,780	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 coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		513,163	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)		513,163	26.00
26.01	Sequestration adjustment (see instructions)		10,263	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		340,903	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)		161,997	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: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 4/26/2024 1:37 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,602,243	1,602,243	1,602,243	1,602,243	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000085	0.001160	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	136	1,859	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,823	117,646	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,959	119,505	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,612,712	1,612,712	1,612,712	1,612,712	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,069,116	2,069,116	2,069,116	2,069,116	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001835	0.074102	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,797	153,326	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,756	272,831	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	341	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	270.24	800.09	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	197	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,162	157,618	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		279,587	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)		159,780	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 4/26/2024 1:37 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		340,903	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)		340,903	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		161,997	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		502,900	7.00

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