

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 3/31/2025 9:29 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN		10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ 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 SCHNECK MEDICAL CENTER (15-0065) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 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	Debbie Mann	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	Debbie Mann		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronica		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	227,348	20,140	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RHC I JACKSON	0		237	0	10.00
10.01	RHC II BROWSTOWN	0		31,052	0	10.01
10.02	RHC III OBGYN	0		91	0	10.02
10.03	RHC IV URGENT CARE	0		47,011	0	10.03
10.04	RHC V SPC IM PEDS	0		86,445	0	10.04
10.05	RHC VI JENNINGS	0		33,820	0	10.05
10.06	RHC VII SCOTT	0		68,346	0	10.06
10.07	RHC VIII WASHINGTON CO	0		18,080	0	10.07
10.08	RHC IX PEDS & ADULT MEDICINE	0		50,173	0	10.08
200.00	TOTAL	0	227,348	355,395	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 3/31/2025 9:29 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 411 WEST TIPTON STREET			PO Box:				1.00		
2.00	City: SEYMOUR			State: IN		Zip Code: 47274-		County: JACKSON		
		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		SCHNECK MEDICAL CENTER	150065	99915	1	07/16/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		SCHNECK MEDICAL CENTER	15U065	99915		03/04/1999	N	P	N
8.00	Swing Beds - NF		SCHNECK MEDICAL CENTER	15U065	99915		03/04/1999	N		O
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		JACKSON COUNTY HOME HEALTH	157155	99915		07/01/1985	N	P	O
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		HOSPICE OF MEMORIAL HOSPITAL	151529	99915		12/09/1994			
15.00	Hospital-Based Health Clinic - RHC		JACKSON PARK	158564	99915		04/06/2022	N	O	O
15.01	Hospital-Based Health Clinic - RHC II		BROWNSTOWN	158565	99915		04/21/2022	N	O	O
15.02	Hospital-Based Health Clinic - RHC III		SCHNECK OBGYN	158566	99915		04/22/2022	N	O	O
15.03	Hospital-Based Health Clinic - RHC IV		SCHNECK URGENT CARE	158568	99915		05/11/2022	N	O	O
15.04	Hospital-Based Health Clinic - RHC V		SCHNECK PMC-IM-PED	158569	99915		05/06/2022	N	O	O
15.05	Hospital-Based Health Clinic - RHC VI		SFC JENNINGS	158575	99915		10/20/2023	N	O	O
15.06	Hospital-Based Health Clinic - RHC VII		SFC SCOTT	158574	99915		12/04/2023	N	O	O
15.07	Hospital-Based Health Clinic - RHC VIII		SFC WASHINGTON COUNTY	158578	99915		09/22/2023	N	O	O
15.08	Hospital-Based Health Clinic - RHC IX		SCHNECK PEDS & ADULT MEDICINE	158586	99915		01/26/2024	N	O	O
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2024	12/31/2024		20.00
21.00	Type of Control (see instructions)						8			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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		1.00	2.00	3.00				
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,505	358	0	0	1,057	151	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)	Y		Y		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00		
		V	XVIII	XIX				
		1.00	2.00	3.00				
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N		N		N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		N		48.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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		V	XVIII	XIX		
		1.00	2.00	3.00		
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	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

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			1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
					1.00	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)						
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?					68.00
					1.00	2.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				N	0
						88.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part I
Date/Time Prepared:
3/31/2025 9:29 am

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)				107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					109.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/31/2025 9:29 am
			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
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		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.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,586,540	0	0
			1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.			124.00
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 3/31/2025 9:29 am	
		1.00	2.00				
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.			N		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.					146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				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
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 3/31/2025 9:29 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part II
Date/Time Prepared:
3/31/2025 9:29 am

		Y/N	Date	
		1.00	2.00	
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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
		1.00	2.00	3.00
			Date	
			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, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date.(see instructions)	N		N
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, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	03/03/2025	Y
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part II
Date/Time Prepared:
3/31/2025 9:29 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA	GERBER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	LGERBER@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 3/31/2025 9:29 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
3/31/2025 9:29 am

Component		Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips	
						Title V	
		1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,640	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,640	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,588	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		58	21,228	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	2	732			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC I JACKSON	88.00				0	26.00
26.01	RHC II BROWSTOWN	88.01				0	26.01
26.02	RHC III OBGYN	88.02				0	26.02
26.03	RHC IV URGENT CARE	88.03				0	26.03
26.04	RHC V SPC IM PEDS	88.04				0	26.04
26.05	RHC VI JENNINGS	88.05				0	26.05
26.06	RHC VII SCOTT	88.06				0	26.06
26.07	RHC VIII WASHINGTON CO	88.07				0	26.07
26.08	RHC IX PEDS & ADULT MEDICINE	88.08				0	26.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		60				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						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0065

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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents			
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
		6.00	7.00	8.00	9.00	10.00		
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,127	1,620	5,050			1.00	
2.00	HMO and other (see instructions)	603	388				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	21	0	52			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)	1,148	1,620	5,102			7.00	
8.00	INTENSIVE CARE UNIT	489	205	2,229			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		1,707	2,494			13.00	
14.00	Total (see instructions)	1,637	3,532	9,825	0.00	791.94	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	2,645	0	8,448	0.00	16.70	22.00	
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00	HOSPICE	166	0	330	0.00	9.14	24.00	
24.10	HOSPICE (non-distinct part)			0			24.10	
25.00	CMHC - CMHC						25.00	
26.00	RHC I JACKSON	0	0	0	0.00	0.00	26.00	
26.01	RHC II BROWSTOWN	695	180	3,639	0.00	4.10	26.01	
26.02	RHC III OBGYN	247	1,673	4,830	0.00	17.61	26.02	
26.03	RHC IV URGENT CARE	557	339	7,800	0.00	10.98	26.03	
26.04	RHC V SPC IM PEDS	4,776	1,885	29,912	0.00	42.00	26.04	
26.05	RHC VI JENNINGS	417	28	5,013	0.00	7.13	26.05	
26.06	RHC VII SCOTT	722	30	8,957	0.00	9.09	26.06	
26.07	RHC VIII WASHINGTON CO	452	2	4,414	0.00	6.03	26.07	
26.08	RHC IX PEDS & ADULT MEDICINE	0	5,204	15,476	0.00	31.84	26.08	
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	946.56	27.00	
28.00	Observation Bed Days		374	2,285			28.00	
29.00	Ambulance Trips	0					29.00	
30.00	Employee discount days (see instruction)			0			30.00	
31.00	Employee discount days - IRF			0			31.00	
32.00	Labor & delivery days (see instructions)	0	151	237			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						34.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	370	543	2,238	1.00
2.00 HMO and other (see instructions)			136	116		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	370	543	2,238	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC I JACKSON	0.00					26.00
26.01 RHC II BROWSTOWN	0.00					26.01
26.02 RHC III OBGYN	0.00					26.02
26.03 RHC IV URGENT CARE	0.00					26.03
26.04 RHC V SPC IM PEDS	0.00					26.04
26.05 RHC VI JENNINGS	0.00					26.05
26.06 RHC VII SCOTT	0.00					26.06
26.07 RHC VIII WASHINGTON CO	0.00					26.07
26.08 RHC IX PEDS & ADULT MEDICINE	0.00					26.08
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

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
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	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	95,363,540	0	95,363,540	1,968,870.00	48.44
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		668,851	0	668,851	5,397.00	123.93
4.00	Physician-Part A - Administrative		1,464,169	0	1,464,169	7,496.00	195.33
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		13,129,718	0	13,129,718	53,239.00	246.62
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,369,727	0	1,369,727	20,100.00	68.15
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		13,397,632	-1,956,838	11,440,794	192,647.00	59.39
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,608,857	0	3,608,857	67,274.00	53.64
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		350,000	0	350,000	2,064.00	169.57
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		18,050,468	0	18,050,468		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,471,191	0	2,471,191		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		115,659	0	115,659		
22.00	Physician Part A - Administrative		181,612	0	181,612		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,396,966	0	1,396,966		
24.00	Wage-related costs (RHC/FQHC)		358,488	0	358,488		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

Period:
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Part II
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		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,070,459	0	1,070,459	21,525.00	49.73	26.00
27.00	Administrative & General	5.00	12,474,442	538,456	13,012,898	257,332.00	50.57	27.00
28.00	Administrative & General under contract (see inst.)		1,070,405	0	1,070,405	3,720.00	287.74	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,769,078	0	1,769,078	47,516.00	37.23	30.00
31.00	Laundry & Linen Service	8.00	50,219	0	50,219	3,056.00	16.43	31.00
32.00	Housekeeping	9.00	1,056,565	0	1,056,565	52,020.00	20.31	32.00
33.00	Housekeeping under contract (see instructions)		208,800	0	208,800	11,140.00	18.74	33.00
34.00	Dietary	10.00	730,549	-508,354	222,195	10,010.00	22.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	508,354	508,354	24,437.00	20.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,804,490	-493	2,803,997	61,949.00	45.26	38.00
39.00	Central Services and Supply	14.00	1,095,135	0	1,095,135	37,934.00	28.87	39.00
40.00	Pharmacy	15.00	1,829,568	0	1,829,568	38,481.00	47.54	40.00
41.00	Medical Records & Medical Records Library	16.00	1,159,760	0	1,159,760	45,361.00	25.57	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	1,513,299	0	1,513,299	53,416.00	28.33	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part III
Date/Time Prepared:
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	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	81,474,449	0	81,474,449	1,904,994.00	42.77	1.00
2.00	Excluded area salaries (see instructions)	13,397,632	-1,956,838	11,440,794	192,647.00	59.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)	68,076,817	1,956,838	70,033,655	1,712,347.00	40.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,958,857	0	3,958,857	69,338.00	57.10	4.00
5.00	Subtotal wage-related costs (see inst.)	18,232,080	0	18,232,080	0.00	26.03	5.00
6.00	Total (sum of lines 3 thru 5)	90,267,754	1,956,838	92,224,592	1,781,685.00	51.76	6.00
7.00	Total overhead cost (see instructions)	26,832,769	537,963	27,370,732	667,897.00	40.98	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part IV
Date/Time Prepared:
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	2,281,299	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	41,673	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	13,304,120	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,979	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	450,071	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	8,816	14.00
15.00	'Workers' Compensation Insurance	259,284	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	6,027,520	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	163,622	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,574,384	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0065

Period:
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Part V
Date/Time Prepared:
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Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,608,857	22,574,384	1.00
2.00	Hospital	3,608,857	22,574,384	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	0	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	0	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	0	14.08
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-7155		Period: From 01/01/2024 To 12/31/2024		Worksheet S-4 Date/Time Prepared: 3/31/2025 9:29 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	716	0	1,310	2,026	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	209.00	0.00	597.00	806.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.45	0.00	1.45	5.00
6.00	Direct Nursing Service			7.41	0.00	7.41	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			3.69	0.00	3.69	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.47	0.00	2.47	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.97	0.00	0.97	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					18020	20.00
20.01						31140	20.01
20.02						99915	20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	980	39	37	0	1,056	21.00
22.00	Skilled Nursing Visit Charges	279,300	11,115	10,545	0	300,960	22.00
23.00	Physical Therapy Visits	858	23	17	3	901	23.00
24.00	Physical Therapy Visit Charges	285,714	7,659	5,661	999	300,033	24.00
25.00	Occupational Therapy Visits	454	27	11	0	492	25.00
26.00	Occupational Therapy Visit Charges	151,182	8,991	3,663	0	163,836	26.00
27.00	Speech Pathology Visits	9	0	0	0	9	27.00
28.00	Speech Pathology Visit Charges	2,997	0	0	0	2,997	28.00
29.00	Medical Social Service Visits	3	2	0	0	5	29.00
30.00	Medical Social Service Visit Charges	1,230	820	0	0	2,050	30.00
31.00	Home Health Aide Visits	176	5	1	0	182	31.00
32.00	Home Health Aide Visit Charges	27,532	785	157	0	28,474	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,480	96	66	3	2,645	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	747,955	29,370	20,026	999	798,350	35.00
36.00	Total Number of Episodes (standard/non outlier)	378		39	1	418	36.00
37.00	Total Number of Outlier Episodes		7		0	7	37.00
38.00	Total Non-Routine Medical Supply Charges	29,785	808	711	0	31,304	38.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8565		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am			
		RHC II		Cost			
		1.00					
1.00	Clinic Address and Identification					1.00	
	Street	806 W. COMMERCE STREET				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	BROWNSTOWN		IN	47220	2.00	
					1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)							
11.00	CLINIC			08:00	17:00	08:00	11.00
		1.00		2.00		3.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00	
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N		0		13.00	
		Provider name		CCN			
		1.00		2.00			
14.00	RHC/FQHC name, CCN					14.00	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County					
		4.00					
2.00	City, State, ZIP Code, County	JACKSON				2.00	

Worksheet S-8

Date/Time Prepared:

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Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8566		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am		
		RHC III		Cost		
		1.00				
1.00	Clinic Address and Identification	411 W. TIPTON STREET				1.00
	Street	City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	SEYMOUR	IN	47274	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	
		1.00	2.00	3.00	4.00	
		1.00		2.00	3.00	
11.00	Facility hours of operations (1)					
	CLINIC	08:00	17:00	08:00	11.00	
		1.00		2.00	3.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		0	12.00	
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				13.00	
		Provider name		CCN		
		1.00		2.00		
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
		County		Total Visits		
		4.00		5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00	
		County				
		4.00				
2.00	City, State, ZIP Code, County	JACKSON			2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0065 Component CCN: 15-8566		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am
					RHC III	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00			11.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8568		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC IV		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		1130 MEDICAL PALACE		
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		SEYMOUR IN 47274		
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		
			1.00		
			2.00		
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)				
6.00	Migrant Health Center (Section 329(d), PHS Act)				
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				
8.00	Appalachian Regional Commission				
9.00	Look-Alikes				
	OTHER (SPECIFY)				
			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		
			1.00		
			2.00		
			3.00		
			4.00		
			5.00		
11.00	Facility hours of operations (1)				
	CLINIC		08:00 17:00 08:00 20:00 08:00		
			1.00		
			2.00		
			3.00		
12.00	Have you received an approval for an exception to the productivity standard?		N 0		
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				
			Provider name		
			CCN		
			1.00		
			2.00		
14.00	RHC/FQHC name, CCN				
			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)				
			County		
			4.00		
2.00	City, State, ZIP Code, County		JACKSON		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0065 Component CCN: 15-8568		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am
					RHC IV	Cost
		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	20:00	08:00	20:00	08:00	20:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	20:00	08:00	17:00	11.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8569		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am			
		RHC V		Cost			
		1.00					
1.00	Clinic Address and Identification					1.00	
	Street	411 W TIPTON				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	SEYMOUR		IN	47274	2.00	
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
		Grant Award		Date			
		1.00		2.00			
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00
		1.00		2.00		3.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00	
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N		0		13.00	
		Provider name		CCN			
		1.00		2.00			
14.00	RHC/FQHC name, CCN					14.00	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County					
		4.00					
2.00	City, State, ZIP Code, County	JACKSON				2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065

Period:

Worksheet S-8

Component CCN: 15-8569

From 01/01/2024

To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

						RHC V		Cost	
			Tuesday	Wednesday		Thursday			
			to	from	to	from	to		
			6.00	7.00	8.00	9.00	10.00		
	Facility hours of operations (1)								
11.00	CLINIC		17:00	07:30	17:00	07:30	17:00	11.00	
			Friday		Saturday				
			from	to	from	to			
			11.00	12.00	13.00	14.00			
	Facility hours of operations (1)								
11.00	CLINIC		07:30	17:00				11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065

Period:

Worksheet S-8

Component CCN: 15-8575

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

3/31/2025 9:29 am

		RHC VI		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		2145 N STATE HWY 3		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		NORTH VERNON IN 47265		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
		1.00	2.00	3.00	4.00
		5.00			
Facility hours of operations (1)					
11.00	CLINIC		08:00	17:00	08:00
		1.00		2.00	3.00
12.00	Have you received an approval for an exception to the productivity standard?		N 0		12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				13.00
			Provider name		CCN
			1.00		2.00
14.00	RHC/FQHC name, CCN				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County		JENNINGS		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0065 Component CCN: 15-8575		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am
					RHC VI	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8574		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am		
		RHC VII		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	1366 N. GARDNER ST.				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	SCOTTSBURG		IN 47170		2.00
				1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00
		Grant Award		Date		
		1.00		2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)						
11.00	CLINIC	08:00		17:00		08:00
		1.00		2.00		3.00
12.00	Have you received an approval for an exception to the productivity standard?	N		0		12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.					13.00
		Provider name		CCN		
		1.00		2.00		
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	SCOTT				2.00

Worksheet S-8

Date/Time Prepared:

Cost

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Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0065 Component CCN: 15-8578		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am		
		RHC VIII		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	403 S. MAIN ST.				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	SALEM		IN	47167	2.00
		1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00
		1.00		2.00		3.00
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N		0		13.00
		Provider name		CCN		
		1.00		2.00		
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	WASHINGTON				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0065 Component CCN: 15-8578		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 3/31/2025 9:29 am
					RHC VIII	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0065

Period:

Worksheet S-8

Component CCN: 15-8586

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

3/31/2025 9:29 am

		RHC IX		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		225 S. PINE ST.		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		SEYMOUR IN 47274		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
		1.00	2.00	3.00	4.00
		1.00		2.00	3.00
11.00	Facility hours of operations (1)				
11.00	CLINIC		08:00	18:00	08:00
		1.00		2.00	3.00
12.00	Have you received an approval for an exception to the productivity standard?				12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.		N 0		13.00
		Provider name		CCN	
		1.00		2.00	
14.00	RHC/FQHC name, CCN				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County		JACKSON		2.00

Worksheet S-8

Date/Time Prepared:
3/31/2025 9:29 am

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HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0065

Period:

Worksheet S-9

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024PARTS I THROUGH IV
Date/Time Prepared:
3/31/2025 9:29 am

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	8,753	62	377	9,192	11.00
12.00	Hospice Inpatient Respite Care	105	0	0	105	12.00
13.00	Hospice General Inpatient Care	68	1	3	72	13.00
14.00	Total Hospice Days	8,926	63	380	9,369	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 3/31/2025 9:29 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0.312090 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	31,324,427		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	109,199,196		6.00
7.00	Medicaid cost (line 1 times line 6)	34,079,977		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,755,550		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,755,550		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,854,205	1,626,382	3,480,587 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	578,679	1,198,849	1,777,528 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)	578,679	1,198,849	1,777,528 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)	621,496		25.01
26.00	Bad debt amount (see instructions)	10,135,081		26.00
27.00	Medicare reimbursable bad debts (see instructions)	249,489		27.00
27.01	Medicare allowable bad debts (see instructions)	383,830		27.01
28.00	Non-Medicare bad debt amount (see instructions)	9,751,251		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,177,609		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	4,955,137		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,710,687		31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 3/31/2025 9:29 am
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0.268170 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)	1,699,905	1,432,053	3,131,958 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	455,864	1,035,034	1,490,898 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)	455,864	1,035,034	1,490,898 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)			542,502 25.01
26.00	Bad debt amount (see instructions)			10,132,845 26.00
27.00	Medicare reimbursable bad debts (see instructions)			243,636 27.00
27.01	Medicare allowable bad debts (see instructions)			374,824 27.01
28.00	Non-Medicare bad debt amount (see instructions)			9,758,021 28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			2,747,996 29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			4,238,894 30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,238,894 31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		13,776,882	13,776,882	-4,112,791	9,664,091
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,070,173	6,070,173
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,070,459	21,216,745	22,287,204	0	22,287,204
5.00	00500	ADMINISTRATIVE & GENERAL	12,474,442	18,675,497	31,149,939	78,380	31,228,319
7.00	00700	OPERATION OF PLANT	1,769,078	3,264,677	5,033,755	0	5,033,755
8.00	00800	LAUNDRY & LINEN SERVICE	50,219	562,558	612,777	0	612,777
9.00	00900	HOUSEKEEPING	1,056,565	557,656	1,614,221	0	1,614,221
10.00	01000	DIETARY	730,549	643,556	1,374,105	-956,174	417,931
11.00	01100	CAFETERIA	0	0	0	956,174	956,174
13.00	01300	NURSING ADMINISTRATION	2,804,490	1,079,481	3,883,971	-116,515	3,767,456
14.00	01400	CENTRAL SERVICES & SUPPLY	1,095,135	11,135,131	12,230,266	-10,448,749	1,781,517
15.00	01500	PHARMACY	1,829,568	18,796,940	20,626,508	-14,526,749	6,099,759
16.00	01600	MEDICAL RECORDS & LIBRARY	1,159,760	239,470	1,399,230	0	1,399,230
18.00	01850	PHYSICIAN PRIVATE PRACTICE	1,513,299	297,956	1,811,255	0	1,811,255
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	668,851	668,851
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,957,929	3,755,691	11,713,620	-5,617,127	6,096,493
31.00	03100	INTENSIVE CARE UNIT	1,988,505	1,766,092	3,754,597	0	3,754,597
43.00	04300	NURSERY	0	0	0	2,144,865	2,144,865
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,801,442	4,633,007	9,434,449	-22,717	9,411,732
51.00	05100	RECOVERY ROOM	612,288	171,089	783,377	0	783,377
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,562,857	1,562,857
53.00	05300	ANESTHESIOLOGY	5,223,643	38,912	5,262,555	-692,851	4,569,704
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,020,331	1,778,411	3,798,742	-99,743	3,698,999
54.01	03630	ULTRA SOUND	565,243	263,615	828,858	22,662	851,520
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	164,976	164,976	-84,428	80,548
57.00	05700	CT SCAN	587,618	943,960	1,531,578	-253,340	1,278,238
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,878	279,708	429,586	-13,657	415,929
60.00	06000	LABORATORY	1,910,033	4,218,228	6,128,261	0	6,128,261
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	290,143	290,143	0	290,143
64.00	06400	INTRAVENOUS THERAPY	318,615	126,402	445,017	0	445,017
65.00	06500	RESPIRATORY THERAPY	1,435,685	537,192	1,972,877	-278,990	1,693,887
66.00	06600	PHYSICAL THERAPY	1,627,014	16,364	1,643,378	-50	1,643,328
67.00	06700	OCCUPATIONAL THERAPY	480,118	57,901	538,019	0	538,019
68.00	06800	SPEECH PATHOLOGY	288,913	2,959	291,872	0	291,872
69.00	06900	ELECTROCARDIOLOGY	184,722	133,154	317,876	-92,448	225,428
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,823,013	3,823,013
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	6,836,195	6,836,195
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,274,936	15,274,936
76.00	03952	WOUND CARE (DIABETES CENTER)	584,143	74,582	658,725	-1,877	656,848
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0
76.02	03951	CASE MANAGEMENT	0	0	0	0	0
76.03	03950	PAIN MANAGEMENT	1,506,055	151,282	1,657,337	-55,861	1,601,476
76.04	03610	SLEEP LAB	299,524	147,023	446,547	62,600	509,147
76.05	03480	ONCOLOGY	2,718,336	828,708	3,547,044	-3,538	3,543,506
76.97	07697	CARDIAC REHABILITATION	197,922	46,311	244,233	0	244,233
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0	0	0	0	0
88.01	08801	RHC II BROWSTOWN	340,895	129,411	470,306	0	470,306
88.02	08802	RHC III OBGYN	2,978,827	290,040	3,268,867	-15,000	3,253,867
88.03	08803	RHC IV URGENT CARE	896,542	210,671	1,107,213	0	1,107,213
88.04	08804	RHC V SPC IM PEDS	3,983,913	443,122	4,427,035	-20,000	4,407,035
88.05	08805	RHC VI JENNINGS	371,338	613,696	985,034	-65,340	919,694
88.06	08806	RHC VII SCOTT	499,333	657,712	1,157,045	0	1,157,045
88.07	08807	RHC VIII WASHINGTON CO	261,308	554,818	816,126	-98,587	717,539
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	0	0	3,374,888	3,374,888
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0
90.02	09002	VEIN CENTER	463,474	131,447	594,921	0	594,921
90.03	09003	OBGYN	0	0	0	0	0
90.04	09004	NEUROSURGERY	983,855	1,717	985,572	0	985,572
90.05	09005	SURGICAL ASSOCIATES	3,372,306	14,743	3,387,049	-795	3,386,254
91.00	09100	EMERGENCY	6,015,726	1,082,868	7,098,594	0	7,098,594
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04952	BEHAVIORAL HEALTH	786,870	3,097	789,967	-20,076	769,891

3/31/2025 9:29 am

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,904,757	128,110	2,032,867	-127,123	1,905,744	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE		685,381	685,381	-685,381	0	113.00
116.00	11600 HOSPICE	666,931	138,324	805,255	83,116	888,371	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	84,537,596	115,757,416	200,295,012	2,548,803	202,843,815	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4,851,535	246,493	5,098,028	-54,000	5,044,028	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	0	882,733	882,733	0	882,733	194.01
194.02	07952 EXTERNAL SVCS MARKETING	257,119	627,067	884,186	0	884,186	194.02
194.03	07953 WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954 PHYSICIAN OFFICES	1,681,372	346,520	2,027,892	-131,648	1,896,244	194.04
194.05	07955 INTEGRATED MEDICINE	556,971	188,846	745,817	-331,650	414,167	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	707,308	98,315	805,623	0	805,623	194.08
194.09	07959 UROLOGY PROF	1,922,868	1,305,526	3,228,394	-1,952,963	1,275,431	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	848,771	71,636	920,407	-78,542	841,865	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	95,363,540	119,524,552	214,888,092	0	214,888,092	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-463,142	9,200,949	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	6,070,173	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,342,648	19,944,556	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,902,596	20,325,723	5.00
7.00	00700	OPERATION OF PLANT	0	5,033,755	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	612,777	8.00
9.00	00900	HOUSEKEEPING	0	1,614,221	9.00
10.00	01000	DIETARY	-45,604	372,327	10.00
11.00	01100	CAFETERIA	-602,627	353,547	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,767,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,781,517	14.00
15.00	01500	PHARMACY	-1,751,489	4,348,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-15,176	1,384,054	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	1,811,255	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-668,851	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-615,175	5,481,318	30.00
31.00	03100	INTENSIVE CARE UNIT	-35,458	3,719,139	31.00
43.00	04300	NURSERY	0	2,144,865	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	22,322	9,434,054	50.00
51.00	05100	RECOVERY ROOM	0	783,377	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,562,857	52.00
53.00	05300	ANESTHESIOLOGY	-4,530,792	38,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,012,307	2,686,692	54.00
54.01	03630	ULTRA SOUND	-8,472	843,048	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	80,548	54.02
57.00	05700	CT SCAN	-28,115	1,250,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	415,929	58.00
60.00	06000	LABORATORY	-59,723	6,068,538	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	290,143	63.00
64.00	06400	INTRAVENOUS THERAPY	0	445,017	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,693,887	65.00
66.00	06600	PHYSICAL THERAPY	0	1,643,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	538,019	67.00
68.00	06800	SPEECH PATHOLOGY	0	291,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	225,428	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,823,013	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,836,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-30,746	15,244,190	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	656,848	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	76.02
76.03	03950	PAIN MANAGEMENT	-1,076,088	525,388	76.03
76.04	03610	SLEEP LAB	0	509,147	76.04
76.05	03480	ONCOLOGY	-1,563,176	1,980,330	76.05
76.97	07697	CARDIAC REHABILITATION	0	244,233	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	470,306	88.01
88.02	08802	RHC III OBGYN	0	3,253,867	88.02
88.03	08803	RHC IV URGENT CARE	0	1,107,213	88.03
88.04	08804	RHC V SPC IM PEDS	0	4,407,035	88.04
88.05	08805	RHC VI JENNINGS	-130	919,564	88.05
88.06	08806	RHC VII SCOTT	0	1,157,045	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	717,539	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	3,374,888	88.08
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	90.01
90.02	09002	VEIN CENTER	-305,388	289,533	90.02
90.03	09003	OBGYN	0	0	90.03
90.04	09004	NEUROSURGERY	-834,958	150,614	90.04
90.05	09005	SURGICAL ASSOCIATES	-2,987,874	398,380	90.05
91.00	09100	EMERGENCY	-3,387,658	3,710,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	-388,788	381,103	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,905,744	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet A
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	888,371	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-33,634,659	169,209,156	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,044,028	192.00
194.00	07950	WELLNESS	0	0	194.00
194.01	07951	JACKSON MOB	0	882,733	194.01
194.02	07952	EXTERNAL SVCS MARKETING	0	884,186	194.02
194.03	07953	WASHINGTON CLINIC	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	1,896,244	194.04
194.05	07955	INTEGRATED MEDICINE	0	414,167	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	194.07
194.08	07958	EMPLOYER CLINIC	0	805,623	194.08
194.09	07959	UROLOGY PROF	0	1,275,431	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	194.11
194.12	07962	SPC	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	0	841,865	194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	-33,634,659	181,253,433	200.00

RECLASSIFICATIONS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
3/31/2025 9:29 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,976,604		1.00
	0		0	5,976,604		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	273,166		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	93,569		2.00
	0		0	366,735		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	508,354	447,820		1.00
	0		508,354	447,820		
	D - BOND INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	685,381		1.00
	0		0	685,381		
	E - NURSERY					
1.00	NURSERY	43.00	1,541,931	602,934		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,123,529	439,328		2.00
	0		2,665,460	1,042,262		
	F - NONPHYSICIAN ANESTHETIST					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	668,851	0		1.00
	0		668,851	0		
	G - HOME HEALTH SOCIAL WORKER					
1.00	HOME HEALTH AGENCY	101.00	493	0		1.00
	0		493	0		
	H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,274,936		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	15,274,936		
	I - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,659,208		1.00
2.00		0.00	0	0		2.00
	0		0	10,659,208		
	J - IMPLANTABLE DEVICE					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	6,836,195		1.00
	0		0	6,836,195		
	K - RESPIRATORY THERAPY DIRECTOR					
1.00	SLEEP LAB	76.04	62,600	0		1.00
	0		62,600	0		
	L - RADIOLOGY DIRECTOR					
1.00	ULTRA SOUND	54.01	23,539	0		1.00
2.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	15,693	0		2.00
3.00	CT SCAN	57.00	23,539	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	23,539	0		4.00
	0		86,310	0		
	M - HOSPICE RECLASS					
1.00	HOSPICE	116.00	127,616	0		1.00
	0		127,616	0		
	N - SCHNECK PEDS & ADULT MED PHYSICIAN					
1.00	RHC IX PEDS & ADULT MEDICINE	88.08	3,178,372	482,512		1.00
2.00		0.00	0	0		2.00
	0		3,178,372	482,512		
	O - MEDICAL DIRECTOR RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	538,456	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00

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RECLASSIFICATIONS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
0			538,456	0	
P - BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	905,266	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	905,266	
500.00	Grand Total: Increases		7,836,512	42,676,919	500.00

RECLASSIFICATIONS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,976,604	9		1.00
			0	5,976,604			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	366,735	12		1.00
2.00		0.00	0	0	12		2.00
			0	366,735			
	C - CAFETERIA						
1.00	DIETARY	10.00	508,354	447,820	0		1.00
			508,354	447,820			
	D - BOND INTEREST						
1.00	INTEREST EXPENSE	113.00	0	685,381	11		1.00
			0	685,381			
	E - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	2,665,460	1,042,262	0		1.00
2.00		0.00	0	0	0		2.00
			2,665,460	1,042,262			
	F - NONPHYSICIAN ANESTHETIST						
1.00	ANESTHESIOLOGY	53.00	668,851	0	0		1.00
			668,851	0			
	G - HOME HEALTH SOCIAL WORKER						
1.00	NURSING ADMINISTRATION	13.00	493	0	0		1.00
			493	0			
	H - DRUGS						
1.00	NURSING ADMINISTRATION	13.00	0	27,115	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,020	0		2.00
3.00	PHARMACY	15.00	0	14,526,749	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	109,349	0		4.00
5.00	OPERATING ROOM	50.00	0	22,717	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,433	0		6.00
7.00	ULTRA SOUND	54.01	0	877	0		7.00
8.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	100,121	0		8.00
9.00	CT SCAN	57.00	0	276,879	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	37,196	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	2,911	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	50	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	92,448	0		13.00
14.00	WOUND CARE (DIABETES CENTER)	76.00	0	1,877	0		14.00
15.00	PAIN MANAGEMENT	76.03	0	55,861	0		15.00
16.00	ONCOLOGY	76.05	0	3,538	0		16.00
17.00	SURGICAL ASSOCIATES	90.05	0	795	0		17.00
			0	15,274,936			
	I - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,445,729	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	213,479	0		2.00
			0	10,659,208			
	J - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,836,195	0		1.00
			0	6,836,195			
	K - RESPIRATORY THERAPY DIRECTOR						
1.00	RESPIRATORY THERAPY	65.00	62,600	0	0		1.00
			62,600	0			
	L - RADIOLOGY DIRECTOR						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	86,310	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
			86,310	0			
	M - HOSPICE RECLASS						
1.00	HOME HEALTH AGENCY	101.00	127,616	0	0		1.00
			127,616	0			
	N - SCHNECK PEDS & ADULT MED PHYSICIAN						
1.00	ADULTS & PEDIATRICS	30.00	1,671,821	118,672	0		1.00
2.00	UROLOGY PROF	194.09	1,506,551	363,840	0		2.00
			3,178,372	482,512			
	O - MEDICAL DIRECTOR RECLASS						
1.00	INTEGRATED MEDICINE	194.05	331,650	0	0		1.00
2.00	BEHAVIORAL HEALTH	93.00	20,076	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	54,000	0	0		3.00
4.00	PULMONARY PROFESSIONAL	194.13	20,000	0	0		4.00
5.00	UROLOGY PROF	194.09	630	0	0		5.00

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RECLASSIFICATIONS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
3/31/2025 9:29 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
6.00	RHC IX PEDS & ADULT MEDICINE	88.08	8,600	0	0	6.00
7.00	ANESTHESIOLOGY	53.00	24,000	0	0	7.00
8.00	HOSPICE	116.00	44,500	0	0	8.00
9.00	RHC V SPC IM PEDS	88.04	20,000	0	0	9.00
10.00	RHC III OBGYN	88.02	15,000	0	0	10.00
	0		538,456	0		
	P - BUILDING RENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93,341	10	1.00
2.00	NURSING ADMINISTRATION	13.00	0	88,907	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,563	0	3.00
4.00	RHC VI JENNINGS	88.05	0	65,340	0	4.00
5.00	RHC VIII WASHINGTON CO	88.07	0	98,587	0	5.00
6.00	RHC IX PEDS & ADULT MEDICINE	88.08	0	277,396	0	6.00
7.00	PHYSICIAN OFFICES	194.04	0	131,648	0	7.00
8.00	UROLOGY PROF	194.09	0	81,942	0	8.00
9.00	PULMONARY PROFESSIONAL	194.13	0	58,542	0	9.00
	TOTALS		0	905,266		
500.00	Grand Total: Decreases		7,836,512	42,676,919		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part I
Date/Time Prepared:
3/31/2025 9:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,751,025	995,969	0	995,969	0	1.00
2.00	Land Improvements	5,008,060	0	0	0	118,567	2.00
3.00	Buildings and Fixtures	155,987,896	6,763,512	0	6,763,512	0	3.00
4.00	Building Improvements	6,713,021	357,495	0	357,495	0	4.00
5.00	Fixed Equipment	9,452,816	2,609,304	0	2,609,304	0	5.00
6.00	Movable Equipment	65,085,034	4,839,529	0	4,839,529	0	6.00
7.00	HIT designated Assets	11,743,459	7,175,303	0	7,175,303	7,127,051	7.00
8.00	Subtotal (sum of lines 1-7)	265,741,311	22,741,112	0	22,741,112	7,245,618	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	265,741,311	22,741,112	0	22,741,112	7,245,618	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,746,994	0				1.00
2.00	Land Improvements	4,889,493	0				2.00
3.00	Buildings and Fixtures	162,751,408	0				3.00
4.00	Building Improvements	7,070,516	0				4.00
5.00	Fixed Equipment	12,062,120	0				5.00
6.00	Movable Equipment	69,924,563	0				6.00
7.00	HIT designated Assets	11,791,711	0				7.00
8.00	Subtotal (sum of lines 1-7)	281,236,805	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	281,236,805	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	13,776,882	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,776,882	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	13,776,882				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	13,776,882				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part III
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	211,312,242	0	211,312,242	0.751368	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	69,924,563	0	69,924,563	0.248632	0	2.00
3.00	Total (sum of lines 1-2)	281,236,805	0	281,236,805	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,800,278	815,873	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,976,604	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,776,882	815,873	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	311,632	273,166	0	0	9,200,949	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	93,569	0	0	6,070,173	2.00
3.00	Total (sum of lines 1-2)	311,632	366,735	0	0	15,271,122	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		A	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-373,749	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-104,308	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-89,393	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-14,209	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-15,780,614			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-602,627	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-30,746	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-15,176	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-668,851	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ASSESSMENT FEE	A	-9,847,345	ADMINISTRATIVE & GENERAL	5.00	0	33.00

3/31/2025 9:29 am

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
3/31/2025 9:29 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 ADULTS AND PEDS MARKETING	A	-1,822	ADULTS & PEDIATRICS	30.00	0	33.01
33.02 SFC JENNINGS MARKETING	A	-130	RHC VI JENNINGS	88.05	0	33.02
33.03 SURGICAL PROF MARKETING	A	-2,034	SURGICAL ASSOCIATES	90.05	0	33.03
33.04 ICCU MARKETING	A	-100	INTENSIVE CARE UNIT	31.00	0	33.04
33.05 PHYSICAN RECRUITMENT	A	-200,004	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 MISC INCOME - DIETARY	B	-45,604	DIETARY	10.00	0	33.06
33.07 340B RETAIL PHARMACY EXP	A	-1,392,917	PHARMACY	15.00	0	33.07
33.08 MISC INCOME - ADMIN & GENERAL	B	-266,529	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 MISC INCOME - OPERATING ROOM	B	22,322	OPERATING ROOM	50.00	0	33.09
33.10 LOBBYING DUES	A	-16,962	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 TELEPHONE OPERATOR BENEFITS	A	-33	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 CRNA OFFSET - BENEFITS	A	-102,401	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 APRN OFFSET	A	-261,489	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 APRN OFFSET	A	-250,265	ADULTS & PEDIATRICS	30.00	0	33.14
33.15 APRN OFFSET	A	-303,792	PAIN MANAGEMENT	76.03	0	33.15
33.16 APRN OFFSET	A	-180,048	NEUROSURGERY	90.04	0	33.16
33.17 APRN OFFSET	A	-252,132	SURGICAL ASSOCIATES	90.05	0	33.17
33.18 APRN OFFSET	A	-121,400	EMERGENCY	91.00	0	33.18
33.19 APRN OFFSET - BENEFITS	A	-209,613	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20 PA - OFFSET	A	-133,515	EMERGENCY	91.00	0	33.20
33.21 PA BENEFITS OFFSET	A	-20,441	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22 EMPLOYEE PHARMACY OFFSET	B	-358,572	PHARMACY	15.00	0	33.22
33.23 PHYSICIAN BENEFITS OFFSET	A	-2,010,160	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-33,634,659				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: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-2

Date/Time Prepared:
3/31/2025 9:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	624,512	0	624,512	211,500	4,256	1.00
2.00	30.00	ADULTS & PEDIATRICS	377,730	280,223	97,507	211,500	144	2.00
3.00	31.00	INTENSIVE CARE UNIT	50,000	0	50,000	211,500	144	3.00
4.00	53.00	ANESTHESIOLOGY	4,530,792	4,530,792	0	239,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,012,307	1,012,307	0	271,900	0	5.00
6.00	54.01	ULTRA SOUND	8,472	8,472	0	271,900	0	6.00
7.00	57.00	CT SCAN	28,115	28,115	0	271,900	0	7.00
8.00	60.00	LABORATORY	300,000	0	300,000	260,300	1,920	8.00
9.00	76.03	PAIN MANAGEMENT	772,296	772,296	0	211,500	0	9.00
10.00	76.04	SLEEP LAB	20,000	0	20,000	211,500	520	10.00
11.00	76.05	ONCOLOGY	1,748,035	1,076,387	671,648	211,500	1,818	11.00
12.00	90.02	VEIN CENTER	315,556	300,556	15,000	211,500	100	12.00
13.00	90.04	NEUROSURGERY	654,910	654,910	0	211,500	0	13.00
14.00	90.05	SURGICAL ASSOCIATES	2,747,740	2,732,740	15,000	211,500	138	14.00
15.00	91.00	EMERGENCY	3,152,743	3,132,743	20,000	211,500	520	15.00
16.00	93.00	BEHAVIORAL HEALTH	388,788	388,788	0	181,300	0	16.00
200.00			16,731,996	14,918,329	1,813,667		9,560	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	432,762	21,638	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	14,642	732	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	14,642	732	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.01	ULTRA SOUND	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	240,277	12,014	0	0	0	8.00
9.00	76.03	PAIN MANAGEMENT	0	0	0	0	0	9.00
10.00	76.04	SLEEP LAB	52,875	2,644	0	0	0	10.00
11.00	76.05	ONCOLOGY	184,859	9,243	0	0	0	11.00
12.00	90.02	VEIN CENTER	10,168	508	0	0	0	12.00
13.00	90.04	NEUROSURGERY	0	0	0	0	0	13.00
14.00	90.05	SURGICAL ASSOCIATES	14,032	702	0	0	0	14.00
15.00	91.00	EMERGENCY	52,875	2,644	0	0	0	15.00
16.00	93.00	BEHAVIORAL HEALTH	0	0	0	0	0	16.00
200.00			1,017,132	50,857	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	432,762	191,750	191,750		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	14,642	82,865	363,088		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	14,642	35,358	35,358		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	4,530,792		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,012,307		5.00
6.00	54.01	ULTRA SOUND	0	0	0	8,472		6.00
7.00	57.00	CT SCAN	0	0	0	28,115		7.00
8.00	60.00	LABORATORY	0	240,277	59,723	59,723		8.00
9.00	76.03	PAIN MANAGEMENT	0	0	0	772,296		9.00
10.00	76.04	SLEEP LAB	0	52,875	0	0		10.00
11.00	76.05	ONCOLOGY	0	184,859	486,789	1,563,176		11.00
12.00	90.02	VEIN CENTER	0	10,168	4,832	305,388		12.00
13.00	90.04	NEUROSURGERY	0	0	0	654,910		13.00
14.00	90.05	SURGICAL ASSOCIATES	0	14,032	968	2,733,708		14.00
15.00	91.00	EMERGENCY	0	52,875	0	3,132,743		15.00
16.00	93.00	BEHAVIORAL HEALTH	0	0	0	388,788		16.00
200.00			0	1,017,132	862,285	15,780,614		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP			
0			1.00	2.00	4.00	4A		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,200,949	9,200,949				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,070,173		6,070,173			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,944,556	93,958	799	20,039,313		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,325,723	788,106	1,178,511	3,875,130	26,167,470	5.00
7.00	00700	OPERATION OF PLANT	5,033,755	495,673	554,676	537,943	6,622,047	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	612,777	30,261	0	15,271	658,309	8.00
9.00	00900	HOUSEKEEPING	1,614,221	46,450	14,589	321,281	1,996,541	9.00
10.00	01000	DIETARY	372,327	52,800	25,731	67,565	518,423	10.00
11.00	01100	CAFETERIA	353,547	120,827	0	154,581	628,955	11.00
13.00	01300	NURSING ADMINISTRATION	3,767,456	254,548	331	852,642	4,874,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,781,517	206,510	153,143	333,010	2,474,180	14.00
15.00	01500	PHARMACY	4,348,270	93,044	228,954	556,337	5,226,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,384,054	31,800	0	352,661	1,768,515	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	1,811,255	0	1,296	460,165	2,272,716	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,481,318	868,642	139,848	939,659	7,429,467	30.00
31.00	03100	INTENSIVE CARE UNIT	3,719,139	480,711	131,463	604,667	4,935,980	31.00
43.00	04300	NURSERY	2,144,865	123,184	0	468,872	2,736,921	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,434,054	771,172	1,468,128	1,460,027	13,133,381	50.00
51.00	05100	RECOVERY ROOM	783,377	121,886	271	186,185	1,091,719	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,562,857	232,056	0	341,644	2,136,557	52.00
53.00	05300	ANESTHESIOLOGY	38,912	2,069	0	0	40,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,686,692	270,592	402,079	588,099	3,947,462	54.00
54.01	03630	ULTRA SOUND	843,048	25,065	63,181	179,037	1,110,331	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	80,548	10,873	60,432	4,772	156,625	54.02
57.00	05700	CT SCAN	1,250,123	29,587	186,625	185,841	1,652,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	415,929	20,855	329,922	52,733	819,439	58.00
60.00	06000	LABORATORY	6,068,538	136,174	169,986	580,805	6,955,503	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	290,143	12,677	0	0	302,820	63.00
64.00	06400	INTRAVENOUS THERAPY	445,017	98,528	464	96,885	640,894	64.00
65.00	06500	RESPIRATORY THERAPY	1,693,887	80,343	96,450	417,529	2,288,209	65.00
66.00	06600	PHYSICAL THERAPY	1,643,328	301,214	7,383	494,744	2,446,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	538,019	0	3,385	145,995	687,399	67.00
68.00	06800	SPEECH PATHOLOGY	291,872	9,478	0	87,853	389,203	68.00
69.00	06900	ELECTROCARDIOLOGY	225,428	7,962	4,816	56,170	294,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,823,013	4,955	0	0	3,827,968	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,836,195	0	0	0	6,836,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,244,190	0	0	0	15,244,190	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	656,848	50,082	1,037	177,627	885,594	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	525,388	176,658	0	130,745	832,791	76.03
76.04	03610	SLEEP LAB	509,147	20,230	26,774	110,115	666,266	76.04
76.05	03480	ONCOLOGY	1,980,330	352,811	470,743	499,285	3,303,169	76.05
76.97	07697	CARDIAC REHABILITATION	244,233	52,945	14,407	60,184	371,769	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	470,306	73,126	119	84,065	627,616	88.01
88.02	08802	RHC III OBGYN	3,253,867	199,414	25,825	277,760	3,756,866	88.02
88.03	08803	RHC IV URGENT CARE	1,107,213	47,677	0	161,826	1,316,716	88.03
88.04	08804	RHC V SPC IM PEDS	4,407,035	409,460	18,088	547,468	5,382,051	88.04
88.05	08805	RHC VI JENNINGS	919,564	180,411	1,136	112,917	1,214,028	88.05
88.06	08806	RHC VII SCOTT	1,157,045	188,132	14,719	117,060	1,476,956	88.06
88.07	08807	RHC VIII WASHINGTON CO	717,539	101,535	24,364	79,459	922,897	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	3,374,888	208,892	46,991	487,222	4,117,993	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	289,533	0	413	49,540	339,486	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	150,614	0	0	45,277	195,891	90.04
90.05	09005	SURGICAL ASSOCIATES	398,380	167,349	1,972	117,811	685,512	90.05
91.00	09100	EMERGENCY	3,710,936	318,004	98,090	996,327	5,123,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A		
93.00	04952	BEHAVIORAL HEALTH	381,103	39,763	0	114,944	535,810	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,905,744	37,982	317	539,165	2,483,208	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	888,371	37,982	0	227,636	1,153,989	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,209,156	8,484,453	5,967,458	19,354,536	167,705,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,044,028	181,686	12,393	218,373	5,456,480	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	882,733	0	0	0	882,733	194.01
194.02	07952	EXTERNAL SVCS MARKETING	884,186	46,426	62,403	78,185	1,071,200	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	1,896,244	109,858	2,979	142,207	2,151,288	194.04
194.05	07955	INTEGRATED MEDICINE	414,167	86,597	0	35,157	535,921	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	805,623	173,315	3,731	152,800	1,135,469	194.08
194.09	07959	UROLOGY PROF	1,275,431	69,542	20,337	0	1,365,310	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	841,865	49,072	872	58,055	949,864	194.13
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)	181,253,433	9,200,949	6,070,173	20,039,313	181,253,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,167,470					5.00
7.00	00700	OPERATION OF PLANT	1,199,835	7,821,882				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	119,278	30,256	807,843			8.00
9.00	00900	HOUSEKEEPING	361,749	46,442	4,518	2,409,250		9.00
10.00	01000	DIETARY	93,932	52,791	0	16,421	681,567	10.00
11.00	01100	CAFETERIA	113,959	120,807	0	37,579	0	11.00
13.00	01300	NURSING ADMINISTRATION	883,287	254,504	0	79,167	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448,292	206,475	0	64,227	0	14.00
15.00	01500	PHARMACY	946,998	93,028	0	28,938	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	320,434	31,795	0	9,890	0	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	411,789	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,346,130	868,492	439,941	270,157	474,326	30.00
31.00	03100	INTENSIVE CARE UNIT	894,340	480,629	39,238	149,506	207,241	31.00
43.00	04300	NURSERY	495,897	123,164	18,374	38,312	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,379,611	771,041	83,117	239,843	0	50.00
51.00	05100	RECOVERY ROOM	197,806	121,865	0	37,908	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	387,118	232,017	6,571	72,172	0	52.00
53.00	05300	ANESTHESIOLOGY	7,425	2,068	0	643	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	715,233	270,546	68,825	84,157	0	54.00
54.01	03630	ULTRA SOUND	201,179	25,061	0	7,796	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	28,379	10,871	0	3,382	0	54.02
57.00	05700	CT SCAN	299,354	29,582	0	9,202	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	148,473	20,852	0	6,486	0	58.00
60.00	06000	LABORATORY	1,260,254	136,151	0	42,352	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	54,867	12,675	0	3,943	0	63.00
64.00	06400	INTRAVENOUS THERAPY	116,122	98,512	0	30,643	0	64.00
65.00	06500	RESPIRATORY THERAPY	414,596	80,329	0	24,988	0	65.00
66.00	06600	PHYSICAL THERAPY	443,307	301,163	39,703	93,681	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,548	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	70,519	9,476	0	2,948	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53,337	7,961	36,083	2,476	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,954	0	1,541	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,762,039	0	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	160,459	50,074	0	15,576	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	150,892	176,628	0	54,943	0	76.03
76.04	03610	SLEEP LAB	120,719	20,227	0	6,292	0	76.04
76.05	03480	ONCOLOGY	598,495	352,751	0	109,728	0	76.05
76.97	07697	CARDIAC REHABILITATION	67,360	52,936	0	16,466	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	113,716	73,114	0	22,743	0	88.01
88.02	08802	RHC III OBGYN	680,699	199,380	0	62,020	0	88.02
88.03	08803	RHC IV URGENT CARE	238,573	47,668	0	14,828	0	88.03
88.04	08804	RHC V SPC IM PEDS	975,163	409,391	0	127,347	0	88.04
88.05	08805	RHC VI JENNINGS	219,967	180,380	0	56,110	0	88.05
88.06	08806	RHC VII SCOTT	267,607	188,100	0	58,511	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	167,218	101,518	0	31,579	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	746,131	208,856	0	64,968	0	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	61,511	0	0	0	0	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	35,493	0	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	124,207	167,321	0	52,047	0	90.05
91.00	09100	EMERGENCY	928,291	317,950	71,473	98,903	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04952	BEHAVIORAL HEALTH	97,082	39,756	0	12,367	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	449,927	37,976	0	11,813	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

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COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	209,089	37,976	0	11,813	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,712,686	7,105,509	807,843	2,186,412	681,567	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	988,649	181,655	0	56,506	0	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	159,941	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	194,089	46,418	0	14,439	0	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	389,788	109,839	0	34,167	0	194.04
194.05	07955	INTEGRATED MEDICINE	97,102	86,582	0	26,933	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	205,733	173,285	0	53,903	0	194.08
194.09	07959	UROLOGY PROF	247,378	69,531	0	21,628	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	172,104	49,063	0	15,262	0	194.13
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)	26,167,470	7,821,882	807,843	2,409,250	681,567	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	901,300					11.00
13.00	01300	NURSING ADMINISTRATION	38,360	6,130,295				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,366	300,722	3,517,262			14.00
15.00	01500	PHARMACY	23,757	305,748	0	6,625,074		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,068	0	0	0	2,158,702	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	32,770	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,596	612,554	0	0	47,452	30.00
31.00	03100	INTENSIVE CARE UNIT	36,589	470,898	0	0	35,652	31.00
43.00	04300	NURSERY	19,662	253,050	0	0	49,147	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,765	1,026,605	0	0	655,808	50.00
51.00	05100	RECOVERY ROOM	7,709	0	0	0	53,031	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,326	184,380	0	0	64,380	52.00
53.00	05300	ANESTHESIOLOGY	10,869	0	0	0	41,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,950	411,200	0	0	65,422	54.00
54.01	03630	ULTRA SOUND	7,299	0	0	0	27,978	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	128	0	0	0	11,532	54.02
57.00	05700	CT SCAN	7,934	0	0	0	168,399	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,614	0	0	0	55,195	58.00
60.00	06000	LABORATORY	39,644	510,212	0	0	153,782	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	2,896	63.00
64.00	06400	INTRAVENOUS THERAPY	4,672	0	0	0	15,196	64.00
65.00	06500	RESPIRATORY THERAPY	23,185	0	0	0	31,136	65.00
66.00	06600	PHYSICAL THERAPY	29,203	375,839	0	0	36,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,085	0	0	0	16,155	67.00
68.00	06800	SPEECH PATHOLOGY	3,443	0	0	0	7,033	68.00
69.00	06900	ELECTROCARDIOLOGY	2,954	38,012	0	0	33,936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,261,495	0	42,331	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	2,255,767	0	45,758	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,625,074	158,282	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	7,275	0	0	0	8,660	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	11,319	0	0	0	4,601	76.03
76.04	03610	SLEEP LAB	701	0	0	0	15,373	76.04
76.05	03480	ONCOLOGY	19,673	0	0	0	62,573	76.05
76.97	07697	CARDIAC REHABILITATION	3,402	0	0	0	1,043	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	0	3,405	88.01
88.02	08802	RHC III OBGYN	22,532	0	0	0	31,348	88.02
88.03	08803	RHC IV URGENT CARE	14,295	183,970	0	0	5,226	88.03
88.04	08804	RHC V SPC IM PEDS	53,789	692,264	0	0	24,777	88.04
88.05	08805	RHC VI JENNINGS	9,116	0	0	0	3,787	88.05
88.06	08806	RHC VII SCOTT	11,605	0	0	0	6,659	88.06
88.07	08807	RHC VIII WASHINGTON CO	7,688	0	0	0	3,235	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	40,618	0	0	0	26,143	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	3,342	0	0	0	9,328	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	4,754	0	0	0	1,470	90.04
90.05	09005	SURGICAL ASSOCIATES	16,159	0	0	0	1,010	90.05
91.00	09100	EMERGENCY	59,428	764,841	0	0	107,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	6,870	0	0	0	3,077	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	10,686	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

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Period:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	9,693	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	815,514	6,130,295	3,517,262	6,625,074	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,388	0	0	0	192.00
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	3,771	0	0	0	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	17,737	0	0	0	194.04
194.05	07955	INTEGRATED MEDICINE	5,913	0	0	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	10,195	0	0	0	194.08
194.09	07959	UROLOGY PROF	6,018	0	0	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	8,764	0	0	0	194.13
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	901,300	6,130,295	3,517,262	6,625,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet B
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Cost Center Description			OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			PHYSICIAN PRIVATE PRACTICE					
			18.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	2,717,275					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,588	0	11,549,703	0	11,549,703	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	7,250,073	0	7,250,073	31.00
43.00	04300	NURSERY	0	0	3,734,527	0	3,734,527	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	18,369,171	0	18,369,171	50.00
51.00	05100	RECOVERY ROOM	0	0	1,510,038	0	1,510,038	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,097,521	0	3,097,521	52.00
53.00	05300	ANESTHESIOLOGY	0	0	103,627	0	103,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,594,795	0	5,594,795	54.00
54.01	03630	ULTRA SOUND	0	0	1,379,644	0	1,379,644	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	210,917	0	210,917	54.02
57.00	05700	CT SCAN	0	0	2,166,647	0	2,166,647	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,053,059	0	1,053,059	58.00
60.00	06000	LABORATORY	0	0	9,097,898	0	9,097,898	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	377,201	0	377,201	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	906,039	0	906,039	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,862,443	0	2,862,443	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,766,301	0	3,766,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	835,187	0	835,187	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	482,622	0	482,622	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	469,135	0	469,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,138,289	0	5,138,289	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	9,137,720	0	9,137,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,789,585	0	24,789,585	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	0	1,127,638	0	1,127,638	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	120,775	0	1,351,949	0	1,351,949	76.03
76.04	03610	SLEEP LAB	0	0	829,578	0	829,578	76.04
76.05	03480	ONCOLOGY	0	0	4,446,389	0	4,446,389	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	512,976	0	512,976	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	55,916	0	896,510	0	896,510	88.01
88.02	08802	RHC III OBGYN	240,411	0	4,993,256	0	4,993,256	88.02
88.03	08803	RHC IV URGENT CARE	152,517	0	1,973,793	0	1,973,793	88.03
88.04	08804	RHC V SPC IM PEDS	573,910	0	8,238,692	0	8,238,692	88.04
88.05	08805	RHC VI JENNINGS	97,262	0	1,780,650	0	1,780,650	88.05
88.06	08806	RHC VII SCOTT	123,817	0	2,133,255	0	2,133,255	88.06
88.07	08807	RHC VIII WASHINGTON CO	82,025	0	1,316,160	0	1,316,160	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	185,398	0	5,390,107	0	5,390,107	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	35,655	0	449,322	0	449,322	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	50,721	0	288,329	0	288,329	90.04
90.05	09005	SURGICAL ASSOCIATES	172,405	0	1,218,661	0	1,218,661	90.05
91.00	09100	EMERGENCY	0	0	7,471,973	0	7,471,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:
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Cost Center Description			OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			PHYSICIAN PRIVATE PRACTICE					
			18.00	19.00	24.00	25.00	26.00	
93.00	04952	BEHAVIORAL HEALTH	73,305	0	768,267	0	768,267	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	2,993,610	0	2,993,610	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		1,422,560	0	1,422,560	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,977,705	0	163,485,817	0	163,485,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	347,696	0	7,064,374	0	7,064,374	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	1,042,674	0	1,042,674	194.01
194.02	07952	EXTERNAL SVCS MARKETING	0	0	1,329,917	0	1,329,917	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	189,251	0	2,892,070	0	2,892,070	194.04
194.05	07955	INTEGRATED MEDICINE	63,086	0	815,537	0	815,537	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	0	0	1,578,585	0	1,578,585	194.08
194.09	07959	UROLOGY PROF	46,024	0	1,755,889	0	1,755,889	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	93,513	0	1,288,570	0	1,288,570	194.13
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,717,275	0	181,253,433	0	181,253,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	93,958	799	94,757	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,837	788,106	1,178,511	1,988,454	5.00
7.00	00700	OPERATION OF PLANT	139,552	495,673	554,676	1,189,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	516,767	30,261	0	547,028	8.00
9.00	00900	HOUSEKEEPING	5,987	46,450	14,589	67,026	9.00
10.00	01000	DIETARY	4,367	52,800	25,731	82,898	10.00
11.00	01100	CAFETERIA	0	120,827	0	120,827	11.00
13.00	01300	NURSING ADMINISTRATION	5,192	254,548	331	260,071	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,990	206,510	153,143	362,643	14.00
15.00	01500	PHARMACY	0	93,044	228,954	321,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,800	0	31,800	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	0	1,296	1,296	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	474	868,642	139,848	1,008,964	30.00
31.00	03100	INTENSIVE CARE UNIT	0	480,711	131,463	612,174	31.00
43.00	04300	NURSERY	0	123,184	0	123,184	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	446,626	771,172	1,468,128	2,685,926	50.00
51.00	05100	RECOVERY ROOM	0	121,886	271	122,157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	232,056	0	232,056	52.00
53.00	05300	ANESTHESIOLOGY	0	2,069	0	2,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	270,592	402,079	672,671	54.00
54.01	03630	ULTRA SOUND	0	25,065	63,181	88,246	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	10,873	60,432	71,305	54.02
57.00	05700	CT SCAN	0	29,587	186,625	216,212	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,855	329,922	350,777	58.00
60.00	06000	LABORATORY	24,140	136,174	169,986	330,300	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	12,677	0	12,677	63.00
64.00	06400	INTRAVENOUS THERAPY	0	98,528	464	98,992	64.00
65.00	06500	RESPIRATORY THERAPY	0	80,343	96,450	176,793	65.00
66.00	06600	PHYSICAL THERAPY	0	301,214	7,383	308,597	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,385	3,385	67.00
68.00	06800	SPEECH PATHOLOGY	1,387	9,478	0	10,865	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,962	4,816	12,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,955	0	4,955	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	14,973	50,082	1,037	66,092	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	0	176,658	0	176,658	76.03
76.04	03610	SLEEP LAB	3,911	20,230	26,774	50,915	76.04
76.05	03480	ONCOLOGY	0	352,811	470,743	823,554	76.05
76.97	07697	CARDIAC REHABILITATION	0	52,945	14,407	67,352	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	73,126	119	73,245	88.01
88.02	08802	RHC III OBGYN	0	199,414	25,825	225,239	88.02
88.03	08803	RHC IV URGENT CARE	0	47,677	0	47,677	88.03
88.04	08804	RHC V SPC IM PEDS	0	409,460	18,088	427,548	88.04
88.05	08805	RHC VI JENNINGS	0	180,411	1,136	181,547	88.05
88.06	08806	RHC VII SCOTT	0	188,132	14,719	202,851	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	101,535	24,364	125,899	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	208,892	46,991	255,883	88.08
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0	0	413	413	90.02
90.03	09003	OBGYN	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	0	167,349	1,972	169,321	90.05
91.00	09100	EMERGENCY	0	318,004	98,090	416,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	0	39,763	0	39,763	93.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	37,982	317	38,299	2,550
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	62,755	37,982	0	100,737	1,076
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,250,958	8,484,453	5,967,458	15,702,869	91,518
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181,686	12,393	194,079	1,033
194.00	07950	WELLNESS	0	0	0	0	0
194.01	07951	JACKSON MOB	0	0	0	0	0
194.02	07952	EXTERNAL SVCS MARKETING	0	46,426	62,403	108,829	370
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0
194.04	07954	PHYSICIAN OFFICES	0	109,858	2,979	112,837	672
194.05	07955	INTEGRATED MEDICINE	0	86,597	0	86,597	166
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0
194.07	07957	PRIMARY CARE	0	0	0	0	0
194.08	07958	EMPLOYER CLINIC	0	173,315	3,731	177,046	723
194.09	07959	UROLOGY PROF	0	69,542	20,337	89,879	0
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0
194.12	07962	SPC	0	0	0	0	0
194.13	07963	PULMONARY PROFESSIONAL	0	49,072	872	49,944	275
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,250,958	9,200,949	6,070,173	16,522,080	94,757

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,006,769					5.00
7.00	00700	OPERATION OF PLANT	92,013	1,284,458				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,147	4,968	561,215			8.00
9.00	00900	HOUSEKEEPING	27,742	7,626	3,139	107,052		9.00
10.00	01000	DIETARY	7,203	8,669	0	730	99,820	10.00
11.00	01100	CAFETERIA	8,739	19,838	0	1,670	0	11.00
13.00	01300	NURSING ADMINISTRATION	67,738	41,793	0	3,518	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,379	33,906	0	2,854	0	14.00
15.00	01500	PHARMACY	72,624	15,276	0	1,286	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,574	5,221	0	439	0	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	31,579	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103,232	142,621	305,630	12,003	69,468	30.00
31.00	03100	INTENSIVE CARE UNIT	68,585	78,926	27,259	6,643	30,352	31.00
43.00	04300	NURSERY	38,030	20,225	12,765	1,702	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	182,488	126,615	57,742	10,657	0	50.00
51.00	05100	RECOVERY ROOM	15,169	20,012	0	1,684	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,687	38,100	4,565	3,207	0	52.00
53.00	05300	ANESTHESIOLOGY	569	340	0	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,850	44,427	47,813	3,739	0	54.00
54.01	03630	ULTRA SOUND	15,428	4,115	0	346	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,176	1,785	0	150	0	54.02
57.00	05700	CT SCAN	22,957	4,858	0	409	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,386	3,424	0	288	0	58.00
60.00	06000	LABORATORY	96,647	22,358	0	1,882	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,208	2,081	0	175	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,905	16,177	0	1,362	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,795	13,191	0	1,110	0	65.00
66.00	06600	PHYSICAL THERAPY	33,996	49,455	27,582	4,163	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,551	0	0	551	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,408	1,556	0	131	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,090	1,307	25,067	110	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	814	0	68	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,847	0	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	12,305	8,223	0	692	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	11,572	29,005	0	2,441	0	76.03
76.04	03610	SLEEP LAB	9,258	3,321	0	280	0	76.04
76.05	03480	ONCOLOGY	45,898	57,926	0	4,876	0	76.05
76.97	07697	CARDIAC REHABILITATION	5,166	8,693	0	732	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	8,721	12,006	0	1,011	0	88.01
88.02	08802	RHC III OBGYN	52,202	32,741	0	2,756	0	88.02
88.03	08803	RHC IV URGENT CARE	18,296	7,828	0	659	0	88.03
88.04	08804	RHC V SPC IM PEDS	74,784	67,227	0	5,658	0	88.04
88.05	08805	RHC VI JENNINGS	16,869	29,621	0	2,493	0	88.05
88.06	08806	RHC VII SCOTT	20,522	30,889	0	2,600	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	12,824	16,671	0	1,403	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	57,220	34,297	0	2,887	0	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	4,717	0	0	0	0	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	2,722	0	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	9,525	27,476	0	2,313	0	90.05
91.00	09100	EMERGENCY	71,189	52,212	49,653	4,395	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04952	BEHAVIORAL HEALTH	7,445	6,528	0	549	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	34,504	6,236	0	525	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	16,035	6,236	0	525	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,818,516	1,166,820	561,215	97,150	99,820	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,818	29,830	0	2,511	0	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	12,266	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	14,884	7,622	0	642	0	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	29,892	18,037	0	1,518	0	194.04
194.05	07955	INTEGRATED MEDICINE	7,447	14,218	0	1,197	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	15,777	28,456	0	2,395	0	194.08
194.09	07959	UROLOGY PROF	18,971	11,418	0	961	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	13,198	8,057	0	678	0	194.13
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)	2,006,769	1,284,458	561,215	107,052	99,820	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	151,805					11.00
13.00	01300	NURSING ADMINISTRATION	6,461	383,613				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,936	18,818	458,111			14.00
15.00	01500	PHARMACY	4,001	19,133		436,949		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,727	0	0	0	68,429	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	5,519	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,016	38,332	0	0	1,508	30.00
31.00	03100	INTENSIVE CARE UNIT	6,163	29,467	0	0	1,133	31.00
43.00	04300	NURSERY	3,312	15,835	0	0	1,562	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,436	64,240	0	0	20,650	50.00
51.00	05100	RECOVERY ROOM	1,298	0	0	0	1,686	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,413	11,538	0	0	2,047	52.00
53.00	05300	ANESTHESIOLOGY	1,831	0	0	0	1,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,381	25,732	0	0	2,080	54.00
54.01	03630	ULTRA SOUND	1,229	0	0	0	889	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	21	0	0	0	367	54.02
57.00	05700	CT SCAN	1,336	0	0	0	5,353	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	440	0	0	0	1,755	58.00
60.00	06000	LABORATORY	6,677	31,927	0	0	4,888	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	92	63.00
64.00	06400	INTRAVENOUS THERAPY	787	0	0	0	483	64.00
65.00	06500	RESPIRATORY THERAPY	3,905	0	0	0	990	65.00
66.00	06600	PHYSICAL THERAPY	4,919	23,519	0	0	1,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,193	0	0	0	514	67.00
68.00	06800	SPEECH PATHOLOGY	580	0	0	0	224	68.00
69.00	06900	ELECTROCARDIOLOGY	497	2,379	0	0	1,079	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	164,305	0	1,346	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	293,806	0	1,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	436,949	5,032	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	1,225	0	0	0	275	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1,907	0	0	0	146	76.03
76.04	03610	SLEEP LAB	118	0	0	0	489	76.04
76.05	03480	ONCOLOGY	3,314	0	0	0	1,989	76.05
76.97	07697	CARDIAC REHABILITATION	573	0	0	0	33	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	0	108	88.01
88.02	08802	RHC III OBGYN	3,795	0	0	0	997	88.02
88.03	08803	RHC IV URGENT CARE	2,408	11,512	0	0	166	88.03
88.04	08804	RHC V SPC IM PEDS	9,060	43,320	0	0	788	88.04
88.05	08805	RHC VI JENNINGS	1,535	0	0	0	120	88.05
88.06	08806	RHC VII SCOTT	1,955	0	0	0	212	88.06
88.07	08807	RHC VIII WASHINGTON CO	1,295	0	0	0	103	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	6,841	0	0	0	831	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	563	0	0	0	297	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	801	0	0	0	47	90.04
90.05	09005	SURGICAL ASSOCIATES	2,722	0	0	0	32	90.05
91.00	09100	EMERGENCY	10,009	47,861	0	0	3,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04952	BEHAVIORAL HEALTH	1,157	0	0	0	98	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	340	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	308	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,356	383,613	458,111	68,429	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,624	0	0	0	192.00
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	635	0	0	0	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	2,987	0	0	0	194.04
194.05	07955	INTEGRATED MEDICINE	996	0	0	0	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	1,717	0	0	0	194.08
194.09	07959	UROLOGY PROF	1,014	0	0	0	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	1,476	0	0	0	194.13
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	151,805	383,613	458,111	68,429	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0065

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Cost Center Description			OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			PHYSICIAN PRIVATE PRACTICE					
			18.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	40,570					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	203		1,694,421	0	1,694,421	30.00
31.00	03100	INTENSIVE CARE UNIT	0		863,561	0	863,561	31.00
43.00	04300	NURSERY	0		218,832	0	218,832	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		3,168,658	0	3,168,658	50.00
51.00	05100	RECOVERY ROOM	0		162,886	0	162,886	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		325,229	0	325,229	52.00
53.00	05300	ANESTHESIOLOGY	0		6,162	0	6,162	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		859,474	0	859,474	54.00
54.01	03630	ULTRA SOUND	0		111,100	0	111,100	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0		75,827	0	75,827	54.02
57.00	05700	CT SCAN	0		252,004	0	252,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		368,319	0	368,319	58.00
60.00	06000	LABORATORY	0		497,426	0	497,426	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		19,233	0	19,233	63.00
64.00	06400	INTRAVENOUS THERAPY	0		127,164	0	127,164	64.00
65.00	06500	RESPIRATORY THERAPY	0		229,758	0	229,758	65.00
66.00	06600	PHYSICAL THERAPY	0		455,739	0	455,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		15,333	0	15,333	67.00
68.00	06800	SPEECH PATHOLOGY	0		19,179	0	19,179	68.00
69.00	06900	ELECTROCARDIOLOGY	0		47,573	0	47,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		171,488	0	171,488	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		295,261	0	295,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		653,828	0	653,828	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0		89,652	0	89,652	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0		0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0		0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1,803		224,150	0	224,150	76.03
76.04	03610	SLEEP LAB	0		64,902	0	64,902	76.04
76.05	03480	ONCOLOGY	0		939,918	0	939,918	76.05
76.97	07697	CARDIAC REHABILITATION	0		82,834	0	82,834	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0		0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	835		96,324	0	96,324	88.01
88.02	08802	RHC III OBGYN	3,589		322,633	0	322,633	88.02
88.03	08803	RHC IV URGENT CARE	2,277		91,588	0	91,588	88.03
88.04	08804	RHC V SPC IM PEDS	8,570		639,544	0	639,544	88.04
88.05	08805	RHC VI JENNINGS	1,452		234,171	0	234,171	88.05
88.06	08806	RHC VII SCOTT	1,849		261,432	0	261,432	88.06
88.07	08807	RHC VIII WASHINGTON CO	1,225		159,796	0	159,796	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	2,768		363,031	0	363,031	88.08
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0		0	0	0	90.01
90.02	09002	VEIN CENTER	532		6,756	0	6,756	90.02
90.03	09003	OBGYN	0		0	0	0	90.03
90.04	09004	NEUROSURGERY	757		4,541	0	4,541	90.04
90.05	09005	SURGICAL ASSOCIATES	2,574		214,520	0	214,520	90.05
91.00	09100	EMERGENCY	0		659,550	0	659,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00

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Cost Center Description			OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			PHYSICIAN PRIVATE PRACTICE					
			18.00	19.00	24.00	25.00	26.00	
93.00	04952	BEHAVIORAL HEALTH	1,094		57,178	0	57,178	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		82,454	0	82,454	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		124,917	0	124,917	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,528	0	15,358,346	0	15,358,346	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,191		314,086	0	314,086	192.00
194.00	07950	WELLNESS	0		0	0	0	194.00
194.01	07951	JACKSON MOB	0		12,266	0	12,266	194.01
194.02	07952	EXTERNAL SVCS MARKETING	0		132,982	0	132,982	194.02
194.03	07953	WASHINGTON CLINIC	0		0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	2,826		168,769	0	168,769	194.04
194.05	07955	INTEGRATED MEDICINE	942		111,563	0	111,563	194.05
194.06	07956	SURGICAL PROFESSIONAL	0		0	0	0	194.06
194.07	07957	PRIMARY CARE	0		0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	0		226,114	0	226,114	194.08
194.09	07959	UROLOGY PROF	687		122,930	0	122,930	194.09
194.10	07960	SCOTTSBURG SPECIAL	0		0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0		0	0	0	194.11
194.12	07962	SPC	0		0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	1,396		75,024	0	75,024	194.13
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,570	0	16,522,080	0	16,522,080	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	382,500					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,243,023				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,906	690	65,901,312			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,763	1,017,922	12,743,816	-26,167,470	144,421,800	5.00
7.00	00700	OPERATION OF PLANT	20,606	479,093	1,769,078	0	6,622,047	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,258	0	50,219	0	658,309	8.00
9.00	00900	HOUSEKEEPING	1,931	12,601	1,056,565	0	1,996,541	9.00
10.00	01000	DIETARY	2,195	22,225	222,195	0	518,423	10.00
11.00	01100	CAFETERIA	5,023	0	508,354	0	628,955	11.00
13.00	01300	NURSING ADMINISTRATION	10,582	286	2,803,997	0	4,874,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,585	132,275	1,095,135	0	2,474,180	14.00
15.00	01500	PHARMACY	3,868	197,756	1,829,568	0	5,226,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,322	0	1,159,760	0	1,768,515	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	1,119	1,513,299	0	2,272,716	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,111	120,792	3,090,160	0	7,429,467	30.00
31.00	03100	INTENSIVE CARE UNIT	19,984	113,549	1,988,505	0	4,935,980	31.00
43.00	04300	NURSERY	5,121	0	1,541,931	0	2,736,921	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,059	1,268,072	4,801,442	0	13,133,381	50.00
51.00	05100	RECOVERY ROOM	5,067	234	612,288	0	1,091,719	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,647	0	1,123,529	0	2,136,557	52.00
53.00	05300	ANESTHESIOLOGY	86	0	0	0	40,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,249	347,290	1,934,021	0	3,947,462	54.00
54.01	03630	ULTRA SOUND	1,042	54,572	588,782	0	1,110,331	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	452	52,197	15,693	0	156,625	54.02
57.00	05700	CT SCAN	1,230	161,195	611,157	0	1,652,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	867	284,965	173,417	0	819,439	58.00
60.00	06000	LABORATORY	5,661	146,823	1,910,033	0	6,955,503	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	527	0	0	0	302,820	63.00
64.00	06400	INTRAVENOUS THERAPY	4,096	401	318,615	0	640,894	64.00
65.00	06500	RESPIRATORY THERAPY	3,340	83,307	1,373,085	0	2,288,209	65.00
66.00	06600	PHYSICAL THERAPY	12,522	6,377	1,627,014	0	2,446,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,924	480,118	0	687,399	67.00
68.00	06800	SPEECH PATHOLOGY	394	0	288,913	0	389,203	68.00
69.00	06900	ELECTROCARDIOLOGY	331	4,160	184,722	0	294,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	206	0	0	-3,827,968	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	-6,836,195	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,244,190	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	2,082	896	584,143	0	885,594	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	7,344	0	429,967	0	832,791	76.03
76.04	03610	SLEEP LAB	841	23,126	362,124	0	666,266	76.04
76.05	03480	ONCOLOGY	14,667	406,597	1,641,949	0	3,303,169	76.05
76.97	07697	CARDIAC REHABILITATION	2,201	12,444	197,922	0	371,769	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	3,040	103	276,457	0	627,616	88.01
88.02	08802	RHC III OBGYN	8,290	22,306	913,440	0	3,756,866	88.02
88.03	08803	RHC IV URGENT CARE	1,982	0	532,182	0	1,316,716	88.03
88.04	08804	RHC V SPC IM PEDS	17,022	15,623	1,800,401	0	5,382,051	88.04
88.05	08805	RHC VI JENNINGS	7,500	981	371,338	0	1,214,028	88.05
88.06	08806	RHC VII SCOTT	7,821	12,713	384,963	0	1,476,956	88.06
88.07	08807	RHC VIII WASHINGTON CO	4,221	21,044	261,308	0	922,897	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	8,684	40,588	1,602,278	0	4,117,993	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0	357	162,918	0	339,486	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	148,897	0	195,891	90.04
90.05	09005	SURGICAL ASSOCIATES	6,957	1,703	387,434	0	685,512	90.05
91.00	09100	EMERGENCY	13,220	84,724	3,276,519	0	5,123,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
93.00	04952	BEHAVIORAL HEALTH	1,653	0	378,006	0	535,810	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,579	274	1,773,097	0	2,483,208	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,579	0	748,602	0	1,153,989	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	352,714	5,154,304	63,649,356	-36,831,633	130,873,535	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,553	10,704	718,142	0	5,456,480	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	882,733	194.01
194.02	07952	EXTERNAL SVCS MARKETING	1,930	53,900	257,119	0	1,071,200	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	4,567	2,573	467,662	0	2,151,288	194.04
194.05	07955	INTEGRATED MEDICINE	3,600	0	115,616	0	535,921	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	7,205	3,223	502,499	0	1,135,469	194.08
194.09	07959	UROLOGY PROF	2,891	17,566	0	0	1,365,310	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	2,040	753	190,918	0	949,864	194.13
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)	9,200,949	6,070,173	20,039,313		26,167,470	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.054769	1.157762	0.304081		0.181188	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			94,757		2,006,769	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001438		0.013895	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: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	325,225				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,258	495,977			8.00
9.00	00900	HOUSEKEEPING	1,931	2,774	322,036		9.00
10.00	01000	DIETARY	2,195	0	2,195	24,896	10.00
11.00	01100	CAFETERIA	5,023	0	5,023	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,582	0	10,582	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,585	0	8,585	0	14.00
15.00	01500	PHARMACY	3,868	0	3,868	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,322	0	1,322	0	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,111	270,103	36,111	17,326	30.00
31.00	03100	INTENSIVE CARE UNIT	19,984	24,090	19,984	7,570	31.00
43.00	04300	NURSERY	5,121	11,281	5,121	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,059	51,030	32,059	0	50.00
51.00	05100	RECOVERY ROOM	5,067	0	5,067	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,647	4,034	9,647	0	52.00
53.00	05300	ANESTHESIOLOGY	86	0	86	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,249	42,255	11,249	0	54.00
54.01	03630	ULTRA SOUND	1,042	0	1,042	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	452	0	452	0	54.02
57.00	05700	CT SCAN	1,230	0	1,230	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	867	0	867	0	58.00
60.00	06000	LABORATORY	5,661	0	5,661	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	527	0	527	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,096	0	4,096	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,340	0	3,340	0	65.00
66.00	06600	PHYSICAL THERAPY	12,522	24,376	12,522	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	394	0	394	0	68.00
69.00	06900	ELECTROCARDIOLOGY	331	22,153	331	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	206	0	206	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	2,082	0	2,082	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	7,344	0	7,344	0	76.03
76.04	03610	SLEEP LAB	841	0	841	0	76.04
76.05	03480	ONCOLOGY	14,667	0	14,667	0	76.05
76.97	07697	CARDIAC REHABILITATION	2,201	0	2,201	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	3,040	0	3,040	0	88.01
88.02	08802	RHC III OBGYN	8,290	0	8,290	0	88.02
88.03	08803	RHC IV URGENT CARE	1,982	0	1,982	0	88.03
88.04	08804	RHC V SPC IM PEDS	17,022	0	17,022	0	88.04
88.05	08805	RHC VI JENNINGS	7,500	0	7,500	0	88.05
88.06	08806	RHC VII SCOTT	7,821	0	7,821	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	4,221	0	4,221	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	8,684	0	8,684	0	88.08
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0	0	0	0	90.02
90.03	09003	OBGYN	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	6,957	0	6,957	0	90.05
91.00	09100	EMERGENCY	13,220	43,881	13,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	1,653	0	1,653	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,579	0	1,579	0	101.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	1,579	0	1,579	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	295,439	495,977	292,250	24,896	1,330,028	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	7,553	0	7,553	0	54,453	192.00
194.00	07950 WELLNESS	0	0	0	0	0	194.00
194.01	07951 JACKSON MOB	0	0	0	0	0	194.01
194.02	07952 EXTERNAL SVCS MARKETING	1,930	0	1,930	0	6,150	194.02
194.03	07953 WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954 PHYSICIAN OFFICES	4,567	0	4,567	0	28,928	194.04
194.05	07955 INTEGRATED MEDICINE	3,600	0	3,600	0	9,643	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957 PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958 EMPLOYER CLINIC	7,205	0	7,205	0	16,627	194.08
194.09	07959 UROLOGY PROF	2,891	0	2,891	0	9,814	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962 SPC	0	0	0	0	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	2,040	0	2,040	0	14,294	194.13
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)	7,821,882	807,843	2,409,250	681,567	901,300	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.050679	1.628791	7.481306	27.376567	0.613156	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,284,458	561,215	107,052	99,820	151,805	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.949444	1.131534	0.332422	4.009479	0.103273	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: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE	
			(DIRECT NRSING HRS)	(COSTED REQUIS.)			PHYSICIAN PRIVATE PRACTICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	776,842					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,108	10,659,208				14.00
15.00	01500	PHARMACY	38,745	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	523,842,108		16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	0	0	0	0	415,349	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,624	0	0	11,514,723	2,077	30.00
31.00	03100	INTENSIVE CARE UNIT	59,673	0	0	8,651,201	0	31.00
43.00	04300	NURSERY	32,067	0	0	11,925,972	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	130,093	0	0	159,150,068	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,868,384	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,365	0	0	15,622,474	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,104,707	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,108	0	0	15,875,351	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	6,789,228	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	2,798,400	0	54.02
57.00	05700	CT SCAN	0	0	0	40,863,734	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,393,626	0	58.00
60.00	06000	LABORATORY	64,655	0	0	37,316,641	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	702,679	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,687,404	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,555,386	0	65.00
66.00	06600	PHYSICAL THERAPY	47,627	0	0	8,914,268	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,920,143	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,706,736	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,817	0	0	8,235,007	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,823,013	0	10,272,000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,836,195	0	11,103,719	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	38,408,589	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	0	0	2,101,458	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	0	0	0	1,116,378	18,461	76.03
76.04	03610	SLEEP LAB	0	0	0	3,730,341	0	76.04
76.05	03480	ONCOLOGY	0	0	0	15,183,874	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	253,031	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	826,354	8,547	88.01
88.02	08802	RHC III OBGYN	0	0	0	7,606,956	36,748	88.02
88.03	08803	RHC IV URGENT CARE	23,313	0	0	1,268,095	23,313	88.03
88.04	08804	RHC V SPC IM PEDS	87,725	0	0	6,012,424	87,725	88.04
88.05	08805	RHC VI JENNINGS	0	0	0	918,936	14,867	88.05
88.06	08806	RHC VII SCOTT	0	0	0	1,615,962	18,926	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	785,007	12,538	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	0	0	6,343,899	28,339	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0	0	0	2,263,585	5,450	90.02
90.03	09003	OBGYN	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	0	356,827	7,753	90.04
90.05	09005	SURGICAL ASSOCIATES	0	0	0	244,991	26,353	90.05
91.00	09100	EMERGENCY	96,922	0	0	26,141,817	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (GROSS CHARGES) 16.00	OTHER GENERAL SERVICE PHYSICIAN PRIVATE PRACTICE (TIME SPENT) 18.00	
93.00	04952	BEHAVIORAL HEALTH	0	0	0	746,650	11,205	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,593,045	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	2,352,038	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	776,842	10,659,208	100	523,842,108	302,302	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	53,147	192.00
194.00	07950	WELLNESS	0	0	0	0	0	194.00
194.01	07951	JACKSON MOB	0	0	0	0	0	194.01
194.02	07952	EXTERNAL SVCS MARKETING	0	0	0	0	0	194.02
194.03	07953	WASHINGTON CLINIC	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	28,928	194.04
194.05	07955	INTEGRATED MEDICINE	0	0	0	0	9,643	194.05
194.06	07956	SURGICAL PROFESSIONAL	0	0	0	0	0	194.06
194.07	07957	PRIMARY CARE	0	0	0	0	0	194.07
194.08	07958	EMPLOYER CLINIC	0	0	0	0	0	194.08
194.09	07959	UROLOGY PROF	0	0	0	0	7,035	194.09
194.10	07960	SCOTTSBURG SPECIAL	0	0	0	0	0	194.10
194.11	07961	BEHAVIORAL HEALTH	0	0	0	0	0	194.11
194.12	07962	SPC	0	0	0	0	0	194.12
194.13	07963	PULMONARY PROFESSIONAL	0	0	0	0	14,294	194.13
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)	6,130,295	3,517,262	6,625,074	2,158,702	2,717,275	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.891302	0.329974	66,250.740000	0.004121	6.542149	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	383,613	458,111	436,949	68,429	40,570	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.493811	0.042978	4,369.490000	0.000131	0.097677	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: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
18.00	01850	PHYSICIAN PRIVATE PRACTICE	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	76.01
76.02	03951	CASE MANAGEMENT	76.02
76.03	03950	PAIN MANAGEMENT	76.03
76.04	03610	SLEEP LAB	76.04
76.05	03480	ONCOLOGY	76.05
76.97	07697	CARDIAC REHABILITATION	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I JACKSON	88.00
88.01	08801	RHC II BROWSTOWN	88.01
88.02	08802	RHC III OBGYN	88.02
88.03	08803	RHC IV URGENT CARE	88.03
88.04	08804	RHC V SPC IM PEDS	88.04
88.05	08805	RHC VI JENNINGS	88.05
88.06	08806	RHC VII SCOTT	88.06
88.07	08807	RHC VIII WASHINGTON CO	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	88.08
90.00	09000	CLINIC	90.00
90.01	09001	PALLIATIVE HEALTH	90.01
90.02	09002	VEIN CENTER	90.02
90.03	09003	OBGYN	90.03
90.04	09004	NEUROSURGERY	90.04
90.05	09005	SURGICAL ASSOCIATES	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04952	BEHAVIORAL HEALTH	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
	SPECIAL PURPOSE COST CENTERS		
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
	NONREIMBURSABLE COST CENTERS		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950 WELLNESS	0	194.00
194.01	07951 JACKSON MOB	0	194.01
194.02	07952 EXTERNAL SVCS MARKETING	0	194.02
194.03	07953 WASHINGTON CLINIC	0	194.03
194.04	07954 PHYSICIAN OFFICES	0	194.04
194.05	07955 INTEGRATED MEDICINE	0	194.05
194.06	07956 SURGICAL PROFESSIONAL	0	194.06
194.07	07957 PRIMARY CARE	0	194.07
194.08	07958 EMPLOYER CLINIC	0	194.08
194.09	07959 UROLOGY PROF	0	194.09
194.10	07960 SCOTTSBURG SPECIAL	0	194.10
194.11	07961 BEHAVIORAL HEALTH	0	194.11
194.12	07962 SPC	0	194.12
194.13	07963 PULMONARY PROFESSIONAL	0	194.13
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)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
3/31/2025 9:29 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	11,549,703		11,549,703	82,865	11,632,568	30.00
31.00	03100	INTENSIVE CARE UNIT	7,250,073		7,250,073	35,358	7,285,431	31.00
43.00	04300	NURSERY	3,734,527		3,734,527	0	3,734,527	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,369,171		18,369,171	0	18,369,171	50.00
51.00	05100	RECOVERY ROOM	1,510,038		1,510,038	0	1,510,038	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,097,521		3,097,521	0	3,097,521	52.00
53.00	05300	ANESTHESIOLOGY	103,627		103,627	0	103,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,594,795		5,594,795	0	5,594,795	54.00
54.01	03630	ULTRA SOUND	1,379,644		1,379,644	0	1,379,644	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	210,917		210,917	0	210,917	54.02
57.00	05700	CT SCAN	2,166,647		2,166,647	0	2,166,647	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,053,059		1,053,059	0	1,053,059	58.00
60.00	06000	LABORATORY	9,097,898		9,097,898	59,723	9,157,621	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	377,201		377,201	0	377,201	63.00
64.00	06400	INTRAVENOUS THERAPY	906,039		906,039	0	906,039	64.00
65.00	06500	RESPIRATORY THERAPY	2,862,443	0	2,862,443	0	2,862,443	65.00
66.00	06600	PHYSICAL THERAPY	3,766,301	0	3,766,301	0	3,766,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	835,187	0	835,187	0	835,187	67.00
68.00	06800	SPEECH PATHOLOGY	482,622	0	482,622	0	482,622	68.00
69.00	06900	ELECTROCARDIOLOGY	469,135		469,135	0	469,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,138,289		5,138,289	0	5,138,289	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,137,720		9,137,720	0	9,137,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,789,585		24,789,585	0	24,789,585	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	1,127,638		1,127,638	0	1,127,638	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0		0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0		0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1,351,949		1,351,949	0	1,351,949	76.03
76.04	03610	SLEEP LAB	829,578		829,578	0	829,578	76.04
76.05	03480	ONCOLOGY	4,446,389		4,446,389	486,789	4,933,178	76.05
76.97	07697	CARDIAC REHABILITATION	512,976		512,976	0	512,976	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0		0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	896,510		896,510	0	896,510	88.01
88.02	08802	RHC III OBGYN	4,993,256		4,993,256	0	4,993,256	88.02
88.03	08803	RHC IV URGENT CARE	1,973,793		1,973,793	0	1,973,793	88.03
88.04	08804	RHC V SPC IM PEDS	8,238,692		8,238,692	0	8,238,692	88.04
88.05	08805	RHC VI JENNINGS	1,780,650		1,780,650	0	1,780,650	88.05
88.06	08806	RHC VII SCOTT	2,133,255		2,133,255	0	2,133,255	88.06
88.07	08807	RHC VIII WASHINGTON CO	1,316,160		1,316,160	0	1,316,160	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	5,390,107		5,390,107	0	5,390,107	88.08
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0		0	0	0	90.01
90.02	09002	VEIN CENTER	449,322		449,322	4,832	454,154	90.02
90.03	09003	OBGYN	0		0	0	0	90.03
90.04	09004	NEUROSURGERY	288,329		288,329	0	288,329	90.04
90.05	09005	SURGICAL ASSOCIATES	1,218,661		1,218,661	968	1,219,629	90.05
91.00	09100	EMERGENCY	7,471,973		7,471,973	0	7,471,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,619,463		3,619,463	0	3,619,463	92.00
93.00	04952	BEHAVIORAL HEALTH	768,267		768,267	0	768,267	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,993,610		2,993,610	0	2,993,610	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
116.00	11600	HOSPICE	1,422,560		1,422,560	0	1,422,560	116.00
200.00		Subtotal (see instructions)	167,105,280	0	167,105,280	670,535	167,775,815	200.00
201.00		Less Observation Beds	3,619,463		3,619,463	0	3,619,463	201.00
202.00		Total (see instructions)	163,485,817	0	163,485,817	670,535	164,156,352	202.00

3/31/2025 9:29 am

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
3/31/2025 9:29 am

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,454,570		9,454,570			30.00	
31.00	03100	INTENSIVE CARE UNIT	8,651,201		8,651,201			31.00	
43.00	04300	NURSERY	11,925,972		11,925,972			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,214,303	146,935,765	159,150,068	0.115420	0.000000	50.00	
51.00	05100	RECOVERY ROOM	767,871	12,100,513	12,868,384	0.117345	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,661,435	961,039	15,622,474	0.198273	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	943,150	9,161,557	10,104,707	0.010255	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,026	15,465,325	15,875,351	0.352420	0.000000	54.00	
54.01	03630	ULTRA SOUND	340,004	6,449,224	6,789,228	0.203211	0.000000	54.01	
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	6,227	2,792,173	2,798,400	0.075371	0.000000	54.02	
57.00	05700	CT SCAN	1,518,237	39,345,497	40,863,734	0.053021	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,451	13,081,175	13,393,626	0.078624	0.000000	58.00	
60.00	06000	LABORATORY	4,535,108	32,781,533	37,316,641	0.243803	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	225,019	477,660	702,679	0.536804	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	312,812	3,374,592	3,687,404	0.245712	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	3,449,053	4,106,333	7,555,386	0.378861	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	401,650	8,512,618	8,914,268	0.422503	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	354,825	3,565,318	3,920,143	0.213050	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	859,918	846,818	1,706,736	0.282775	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	759,338	7,475,669	8,235,007	0.056968	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,477,554	8,794,446	10,272,000	0.500223	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,879,687	9,224,032	11,103,719	0.822942	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,665,125	35,743,464	38,408,589	0.645418	0.000000	73.00	
76.00	03952	WOUND CARE (DIABETES CENTER)	42,700	2,058,758	2,101,458	0.536598	0.000000	76.00	
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0.000000	0.000000	76.01	
76.02	03951	CASE MANAGEMENT	0	0	0	0.000000	0.000000	76.02	
76.03	03950	PAIN MANAGEMENT	0	1,116,378	1,116,378	1.211014	0.000000	76.03	
76.04	03610	SLEEP LAB	4,377	3,725,964	3,730,341	0.222387	0.000000	76.04	
76.05	03480	ONCOLOGY	32,089	15,151,785	15,183,874	0.292836	0.000000	76.05	
76.97	07697	CARDIAC REHABILITATION	143	252,888	253,031	2.027325	0.000000	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0			88.00	
88.01	08801	RHC II BROWSTOWN	0	826,354	826,354			88.01	
88.02	08802	RHC III OBGYN	2,182,615	5,424,341	7,606,956			88.02	
88.03	08803	RHC IV URGENT CARE	0	1,268,095	1,268,095			88.03	
88.04	08804	RHC V SPC IM PEDS	0	6,012,424	6,012,424			88.04	
88.05	08805	RHC VI JENNINGS	0	918,936	918,936			88.05	
88.06	08806	RHC VII SCOTT	0	1,615,962	1,615,962			88.06	
88.07	08807	RHC VIII WASHINGTON CO	0	785,007	785,007			88.07	
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	6,343,899	6,343,899			88.08	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09001	PALLIATIVE HEALTH	0	0	0	0.000000	0.000000	90.01	
90.02	09002	VEIN CENTER	0	2,263,585	2,263,585	0.198500	0.000000	90.02	
90.03	09003	OBGYN	0	0	0	0.000000	0.000000	90.03	
90.04	09004	NEUROSURGERY	0	356,827	356,827	0.808036	0.000000	90.04	
90.05	09005	SURGICAL ASSOCIATES	0	244,991	244,991	4.974309	0.000000	90.05	
91.00	09100	EMERGENCY	1,759,893	24,381,924	26,141,817	0.285825	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	244,742	1,815,411	2,060,153	1.756890	0.000000	92.00	
93.00	04952	BEHAVIORAL HEALTH	0	746,650	746,650	1.028952	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,593,045	2,593,045			101.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	2,352,038	2,352,038			116.00	
200.00		Subtotal (see instructions)	82,392,095	441,450,013	523,842,108			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	82,392,095	441,450,013	523,842,108			202.00	

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COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 3/31/2025 9:29 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.115420		50.00
51.00	05100	RECOVERY ROOM	0.117345		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.198273		52.00
53.00	05300	ANESTHESIOLOGY	0.010255		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.352420		54.00
54.01	03630	ULTRA SOUND	0.203211		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.075371		54.02
57.00	05700	CT SCAN	0.053021		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078624		58.00
60.00	06000	LABORATORY	0.245403		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.536804		63.00
64.00	06400	INTRAVENOUS THERAPY	0.245712		64.00
65.00	06500	RESPIRATORY THERAPY	0.378861		65.00
66.00	06600	PHYSICAL THERAPY	0.422503		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.213050		67.00
68.00	06800	SPEECH PATHOLOGY	0.282775		68.00
69.00	06900	ELECTROCARDIOLOGY	0.056968		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.500223		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.822942		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645418		73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.536598		76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000		76.01
76.02	03951	CASE MANAGEMENT	0.000000		76.02
76.03	03950	PAIN MANAGEMENT	1.211014		76.03
76.04	03610	SLEEP LAB	0.222387		76.04
76.05	03480	ONCOLOGY	0.324896		76.05
76.97	07697	CARDIAC REHABILITATION	2.027325		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I JACKSON			88.00
88.01	08801	RHC II BROWSTOWN			88.01
88.02	08802	RHC III OBGYN			88.02
88.03	08803	RHC IV URGENT CARE			88.03
88.04	08804	RHC V SPC IM PEDS			88.04
88.05	08805	RHC VI JENNINGS			88.05
88.06	08806	RHC VII SCOTT			88.06
88.07	08807	RHC VIII WASHINGTON CO			88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE			88.08
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PALLIATIVE HEALTH	0.000000		90.01
90.02	09002	VEIN CENTER	0.200635		90.02
90.03	09003	OBGYN	0.000000		90.03
90.04	09004	NEUROSURGERY	0.808036		90.04
90.05	09005	SURGICAL ASSOCIATES	4.978260		90.05
91.00	09100	EMERGENCY	0.285825		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.756890		92.00
93.00	04952	BEHAVIORAL HEALTH	1.028952		93.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
3/31/2025 9:29 am

			Title XIX		Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	11,549,703		11,549,703	82,865	11,632,568
31.00	03100	INTENSIVE CARE UNIT	7,250,073		7,250,073	35,358	7,285,431
43.00	04300	NURSERY	3,734,527		3,734,527	0	3,734,527
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,369,171		18,369,171	0	18,369,171
51.00	05100	RECOVERY ROOM	1,510,038		1,510,038	0	1,510,038
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,097,521		3,097,521	0	3,097,521
53.00	05300	ANESTHESIOLOGY	103,627		103,627	0	103,627
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,594,795		5,594,795	0	5,594,795
54.01	03630	ULTRA SOUND	1,379,644		1,379,644	0	1,379,644
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	210,917		210,917	0	210,917
57.00	05700	CT SCAN	2,166,647		2,166,647	0	2,166,647
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,053,059		1,053,059	0	1,053,059
60.00	06000	LABORATORY	9,097,898		9,097,898	59,723	9,157,621
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	377,201		377,201	0	377,201
64.00	06400	INTRAVENOUS THERAPY	906,039		906,039	0	906,039
65.00	06500	RESPIRATORY THERAPY	2,862,443	0	2,862,443	0	2,862,443
66.00	06600	PHYSICAL THERAPY	3,766,301	0	3,766,301	0	3,766,301
67.00	06700	OCCUPATIONAL THERAPY	835,187	0	835,187	0	835,187
68.00	06800	SPEECH PATHOLOGY	482,622	0	482,622	0	482,622
69.00	06900	ELECTROCARDIOLOGY	469,135		469,135	0	469,135
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,138,289		5,138,289	0	5,138,289
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,137,720		9,137,720	0	9,137,720
73.00	07300	DRUGS CHARGED TO PATIENTS	24,789,585		24,789,585	0	24,789,585
76.00	03952	WOUND CARE (DIABETES CENTER)	1,127,638		1,127,638	0	1,127,638
76.01	03953	OTHER ANCILLARY CMS LINE	0		0	0	0
76.02	03951	CASE MANAGEMENT	0		0	0	0
76.03	03950	PAIN MANAGEMENT	1,351,949		1,351,949	0	1,351,949
76.04	03610	SLEEP LAB	829,578		829,578	0	829,578
76.05	03480	ONCOLOGY	4,446,389		4,446,389	486,789	4,933,178
76.97	07697	CARDIAC REHABILITATION	512,976		512,976	0	512,976
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0		0	0	0
88.01	08801	RHC II BROWSTOWN	896,510		896,510	0	896,510
88.02	08802	RHC III OBGYN	4,993,256		4,993,256	0	4,993,256
88.03	08803	RHC IV URGENT CARE	1,973,793		1,973,793	0	1,973,793
88.04	08804	RHC V SPC IM PEDS	8,238,692		8,238,692	0	8,238,692
88.05	08805	RHC VI JENNINGS	1,780,650		1,780,650	0	1,780,650
88.06	08806	RHC VII SCOTT	2,133,255		2,133,255	0	2,133,255
88.07	08807	RHC VIII WASHINGTON CO	1,316,160		1,316,160	0	1,316,160
88.08	08808	RHC IX PEDS & ADULT MEDICINE	5,390,107		5,390,107	0	5,390,107
90.00	09000	CLINIC	0		0	0	0
90.01	09001	PALLIATIVE HEALTH	0		0	0	0
90.02	09002	VEIN CENTER	449,322		449,322	4,832	454,154
90.03	09003	OBGYN	0		0	0	0
90.04	09004	NEUROSURGERY	288,329		288,329	0	288,329
90.05	09005	SURGICAL ASSOCIATES	1,218,661		1,218,661	968	1,219,629
91.00	09100	EMERGENCY	7,471,973		7,471,973	0	7,471,973
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,619,463		3,619,463	0	3,619,463
93.00	04952	BEHAVIORAL HEALTH	768,267		768,267	0	768,267
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,993,610		2,993,610	0	2,993,610
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0		0	0	0
116.00	11600	HOSPICE	1,422,560		1,422,560	0	1,422,560
200.00		Subtotal (see instructions)	167,105,280	0	167,105,280	670,535	167,775,815
201.00		Less Observation Beds	3,619,463		3,619,463	0	3,619,463
202.00		Total (see instructions)	163,485,817	0	163,485,817	670,535	164,156,352

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COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet C Part I Date/Time Prepared: 3/31/2025 9:29 am		
					Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	9,454,570		9,454,570					30.00	
31.00	03100	INTENSIVE CARE UNIT	8,651,201		8,651,201					31.00	
43.00	04300	NURSERY	11,925,972		11,925,972					43.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	12,214,303	146,935,765	159,150,068	0.115420	0.000000			50.00	
51.00	05100	RECOVERY ROOM	767,871	12,100,513	12,868,384	0.117345	0.000000			51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,661,435	961,039	15,622,474	0.198273	0.000000			52.00	
53.00	05300	ANESTHESIOLOGY	943,150	9,161,557	10,104,707	0.010255	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,026	15,465,325	15,875,351	0.352420	0.000000			54.00	
54.01	03630	ULTRA SOUND	340,004	6,449,224	6,789,228	0.203211	0.000000			54.01	
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	6,227	2,792,173	2,798,400	0.075371	0.000000			54.02	
57.00	05700	CT SCAN	1,518,237	39,345,497	40,863,734	0.053021	0.000000			57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,451	13,081,175	13,393,626	0.078624	0.000000			58.00	
60.00	06000	LABORATORY	4,535,108	32,781,533	37,316,641	0.243803	0.000000			60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	225,019	477,660	702,679	0.536804	0.000000			63.00	
64.00	06400	INTRAVENOUS THERAPY	312,812	3,374,592	3,687,404	0.245712	0.000000			64.00	
65.00	06500	RESPIRATORY THERAPY	3,449,053	4,106,333	7,555,386	0.378861	0.000000			65.00	
66.00	06600	PHYSICAL THERAPY	401,650	8,512,618	8,914,268	0.422503	0.000000			66.00	
67.00	06700	OCCUPATIONAL THERAPY	354,825	3,565,318	3,920,143	0.213050	0.000000			67.00	
68.00	06800	SPEECH PATHOLOGY	859,918	846,818	1,706,736	0.282775	0.000000			68.00	
69.00	06900	ELECTROCARDIOLOGY	759,338	7,475,669	8,235,007	0.056968	0.000000			69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,477,554	8,794,446	10,272,000	0.500223	0.000000			71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,879,687	9,224,032	11,103,719	0.822942	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,665,125	35,743,464	38,408,589	0.645418	0.000000			73.00	
76.00	03952	WOUND CARE (DIABETES CENTER)	42,700	2,058,758	2,101,458	0.536598	0.000000			76.00	
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0.000000	0.000000			76.01	
76.02	03951	CASE MANAGEMENT	0	0	0	0.000000	0.000000			76.02	
76.03	03950	PAIN MANAGEMENT	0	1,116,378	1,116,378	1.211014	0.000000			76.03	
76.04	03610	SLEEP LAB	4,377	3,725,964	3,730,341	0.222387	0.000000			76.04	
76.05	03480	ONCOLOGY	32,089	15,151,785	15,183,874	0.292836	0.000000			76.05	
76.97	07697	CARDIAC REHABILITATION	143	252,888	253,031	2.027325	0.000000			76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000			77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000			78.00	
OUTPATIENT SERVICE COST CENTERS											
88.00	08800	RHC I JACKSON	0	0	0	0.000000	0.000000			88.00	
88.01	08801	RHC II BROWSTOWN	0	826,354	826,354	1.084898	0.000000			88.01	
88.02	08802	RHC III OBGYN	2,182,615	5,424,341	7,606,956	0.656407	0.000000			88.02	
88.03	08803	RHC IV URGENT CARE	0	1,268,095	1,268,095	1.556502	0.000000			88.03	
88.04	08804	RHC V SPC IM PEDS	0	6,012,424	6,012,424	1.370278	0.000000			88.04	
88.05	08805	RHC VI JENNINGS	0	918,936	918,936	1.937730	0.000000			88.05	
88.06	08806	RHC VII SCOTT	0	1,615,962	1,615,962	1.320115	0.000000			88.06	
88.07	08807	RHC VIII WASHINGTON CO	0	785,007	785,007	1.676622	0.000000			88.07	
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	6,343,899	6,343,899	0.849652	0.000000			88.08	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000			90.00	
90.01	09001	PALLIATIVE HEALTH	0	0	0	0.000000	0.000000			90.01	
90.02	09002	VEIN CENTER	0	2,263,585	2,263,585	0.198500	0.000000			90.02	
90.03	09003	OBGYN	0	0	0	0.000000	0.000000			90.03	
90.04	09004	NEUROSURGERY	0	356,827	356,827	0.808036	0.000000			90.04	
90.05	09005	SURGICAL ASSOCIATES	0	244,991	244,991	4.974309	0.000000			90.05	
91.00	09100	EMERGENCY	1,759,893	24,381,924	26,141,817	0.285825	0.000000			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	244,742	1,815,411	2,060,153	1.756890	0.000000			92.00	
93.00	04952	BEHAVIORAL HEALTH	0	746,650	746,650	1.028952	0.000000			93.00	
OTHER REIMBURSABLE COST CENTERS											
101.00	10100	HOME HEALTH AGENCY	0	2,593,045	2,593,045					101.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0					102.00	
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE								113.00	
116.00	11600	HOSPICE	0	2,352,038	2,352,038					116.00	
200.00		Subtotal (see instructions)	82,392,095	441,450,013	523,842,108					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	82,392,095	441,450,013	523,842,108					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.000000		76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000		76.01
76.02	03951	CASE MANAGEMENT	0.000000		76.02
76.03	03950	PAIN MANAGEMENT	0.000000		76.03
76.04	03610	SLEEP LAB	0.000000		76.04
76.05	03480	ONCOLOGY	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0.000000		88.00
88.01	08801	RHC II BROWSTOWN	0.000000		88.01
88.02	08802	RHC III OBGYN	0.000000		88.02
88.03	08803	RHC IV URGENT CARE	0.000000		88.03
88.04	08804	RHC V SPC IM PEDS	0.000000		88.04
88.05	08805	RHC VI JENNINGS	0.000000		88.05
88.06	08806	RHC VII SCOTT	0.000000		88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000		88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0.000000		88.08
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PALLIATIVE HEALTH	0.000000		90.01
90.02	09002	VEIN CENTER	0.000000		90.02
90.03	09003	OBGYN	0.000000		90.03
90.04	09004	NEUROSURGERY	0.000000		90.04
90.05	09005	SURGICAL ASSOCIATES	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04952	BEHAVIORAL HEALTH	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part I
Date/Time Prepared:
3/31/2025 9:29 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,694,421	2,021	1,692,400	7,335	230.73	30.00
31.00	INTENSIVE CARE UNIT	863,561		863,561	2,229	387.42	31.00
43.00	NURSERY	218,832		218,832	2,494	87.74	43.00
200.00	Total (lines 30 through 199)	2,776,814		2,774,793	12,058		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	1,127	260,033				30.00
31.00	INTENSIVE CARE UNIT	489	189,448				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	1,616	449,481				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Prepared: 3/31/2025 9:29 am			
				Title XVIII		Hospital		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,168,658	159,150,068	0.019910	4,078,636	81,206	50.00	
51.00	05100	RECOVERY ROOM	162,886	12,868,384	0.012658	202,375	2,562	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	325,229	15,622,474	0.020818	960,677	19,999	52.00	
53.00	05300	ANESTHESIOLOGY	6,162	10,104,707	0.000610	207,485	127	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,474	15,875,351	0.054139	204,350	11,063	54.00	
54.01	03630	ULTRA SOUND	111,100	6,789,228	0.016364	74,076	1,212	54.01	
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	75,827	2,798,400	0.027097	0	0	54.02	
57.00	05700	CT SCAN	252,004	40,863,734	0.006167	846,114	5,218	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	368,319	13,393,626	0.027500	133,987	3,685	58.00	
60.00	06000	LABORATORY	497,426	37,316,641	0.013330	877,002	11,690	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,233	702,679	0.027371	54,699	1,497	63.00	
64.00	06400	INTRAVENOUS THERAPY	127,164	3,687,404	0.034486	79,502	2,742	64.00	
65.00	06500	RESPIRATORY THERAPY	229,758	7,555,386	0.030410	1,230,966	37,434	65.00	
66.00	06600	PHYSICAL THERAPY	455,739	8,914,268	0.051125	136,124	6,959	66.00	
67.00	06700	OCCUPATIONAL THERAPY	15,333	3,920,143	0.003911	128,537	503	67.00	
68.00	06800	SPEECH PATHOLOGY	19,179	1,706,736	0.011237	44,852	504	68.00	
69.00	06900	ELECTROCARDIOLOGY	47,573	8,235,007	0.005777	332,789	1,923	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,488	10,272,000	0.016695	599,137	10,003	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	295,261	11,103,719	0.026591	825,869	21,961	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	653,828	38,408,589	0.017023	847,346	14,424	73.00	
76.00	03952	WOUND CARE (DIABETES CENTER)	89,652	2,101,458	0.042662	5,552	237	76.00	
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0.000000	0	0	76.01	
76.02	03951	CASE MANAGEMENT	0	0	0.000000	0	0	76.02	
76.03	03950	PAIN MANAGEMENT	224,150	1,116,378	0.200783	0	0	76.03	
76.04	03610	SLEEP LAB	64,902	3,730,341	0.017398	0	0	76.04	
76.05	03480	ONCOLOGY	939,918	15,183,874	0.061902	1,791	111	76.05	
76.97	07697	CARDIAC REHABILITATION	82,834	253,031	0.327367	0	0	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I JACKSON	0	0	0.000000	0	0	88.00	
88.01	08801	RHC II BROWSTOWN	96,324	826,354	0.116565	0	0	88.01	
88.02	08802	RHC III OBGYN	322,633	7,606,956	0.042413	0	0	88.02	
88.03	08803	RHC IV URGENT CARE	91,588	1,268,095	0.072225	0	0	88.03	
88.04	08804	RHC V SPC IM PEDS	639,544	6,012,424	0.106370	0	0	88.04	
88.05	08805	RHC VI JENNINGS	234,171	918,936	0.254828	0	0	88.05	
88.06	08806	RHC VII SCOTT	261,432	1,615,962	0.161781	0	0	88.06	
88.07	08807	RHC VIII WASHINGTON CO	159,796	785,007	0.203560	0	0	88.07	
88.08	08808	RHC IX PEDS & ADULT MEDICINE	363,031	6,343,899	0.057225	0	0	88.08	
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00	
90.01	09001	PALLIATIVE HEALTH	0	0	0.000000	0	0	90.01	
90.02	09002	VEIN CENTER	6,756	2,263,585	0.002985	0	0	90.02	
90.03	09003	OBGYN	0	0	0.000000	0	0	90.03	
90.04	09004	NEUROSURGERY	4,541	356,827	0.012726	0	0	90.04	
90.05	09005	SURGICAL ASSOCIATES	214,520	244,991	0.875624	0	0	90.05	
91.00	09100	EMERGENCY	659,550	26,141,817	0.025230	511,133	12,896	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	527,218	2,060,153	0.255912	10,338	2,646	92.00	
93.00	04952	BEHAVIORAL HEALTH	57,178	746,650	0.076579	0	0	93.00	
200.00	Total (lines 50 through 199)		12,901,379	488,865,282		12,393,337	250,602	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part III Date/Time Prepared: 3/31/2025 9:29 am	
					Title XVIII		Hospital		PPS	
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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	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	7,335	0.00	1,127	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,229	0.00	489	0	31.00	
43.00	04300	NURSERY		0	2,494	0.00	0	0	43.00	
200.00		Total (lines 30 through 199)		0	12,058		1,616	0	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
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 3/31/2025 9:29 am	
				Title XVIII		Hospital		PPS	
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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	0	0	0	0	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	0	0	0	0	0	0	76.03
76.04	03610	SLEEP LAB	0	0	0	0	0	0	76.04
76.05	03480	ONCOLOGY	0	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON	0	0	0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	0	0	0	88.01
88.02	08802	RHC III OBGYN	0	0	0	0	0	0	88.02
88.03	08803	RHC IV URGENT CARE	0	0	0	0	0	0	88.03
88.04	08804	RHC V SPC IM PEDS	0	0	0	0	0	0	88.04
88.05	08805	RHC VI JENNINGS	0	0	0	0	0	0	88.05
88.06	08806	RHC VII SCOTT	0	0	0	0	0	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	0	0	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0	0	90.01
90.02	09002	VEIN CENTER	0	0	0	0	0	0	90.02
90.03	09003	OBGYN	0	0	0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0	0	0	0	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	0	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04952	BEHAVIORAL HEALTH	0	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Title XVIII		Hospital		PPS	
		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	159,150,068	0.000000 50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,868,384	0.000000 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,622,474	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,104,707	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,875,351	0.000000 54.00
54.01	03630	ULTRA SOUND	0	0	0	6,789,228	0.000000 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	2,798,400	0.000000 54.02
57.00	05700	CT SCAN	0	0	0	40,863,734	0.000000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,393,626	0.000000 58.00
60.00	06000	LABORATORY	0	0	0	37,316,641	0.000000 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	702,679	0.000000 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,687,404	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,555,386	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,914,268	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,920,143	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,706,736	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,235,007	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,272,000	0.000000 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	11,103,719	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,408,589	0.000000 73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	0	0	2,101,458	0.000000 76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0	0	0	0.000000 76.01
76.02	03951	CASE MANAGEMENT	0	0	0	0	0.000000 76.02
76.03	03950	PAIN MANAGEMENT	0	0	0	1,116,378	0.000000 76.03
76.04	03610	SLEEP LAB	0	0	0	3,730,341	0.000000 76.04
76.05	03480	ONCOLOGY	0	0	0	15,183,874	0.000000 76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	253,031	0.000000 76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000 78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I JACKSON	0	0	0	0	0.000000 88.00
88.01	08801	RHC II BROWSTOWN	0	0	0	826,354	0.000000 88.01
88.02	08802	RHC III OBGYN	0	0	0	7,606,956	0.000000 88.02
88.03	08803	RHC IV URGENT CARE	0	0	0	1,268,095	0.000000 88.03
88.04	08804	RHC V SPC IM PEDS	0	0	0	6,012,424	0.000000 88.04
88.05	08805	RHC VI JENNINGS	0	0	0	918,936	0.000000 88.05
88.06	08806	RHC VII SCOTT	0	0	0	1,615,962	0.000000 88.06
88.07	08807	RHC VIII WASHINGTON CO	0	0	0	785,007	0.000000 88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0	0	0	6,343,899	0.000000 88.08
90.00	09000	CLINIC	0	0	0	0	0.000000 90.00
90.01	09001	PALLIATIVE HEALTH	0	0	0	0	0.000000 90.01
90.02	09002	VEIN CENTER	0	0	0	2,263,585	0.000000 90.02
90.03	09003	OBGYN	0	0	0	0	0.000000 90.03
90.04	09004	NEUROSURGERY	0	0	0	356,827	0.000000 90.04
90.05	09005	SURGICAL ASSOCIATES	0	0	0	244,991	0.000000 90.05
91.00	09100	EMERGENCY	0	0	0	26,141,817	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,060,153	0.000000 92.00
93.00	04952	BEHAVIORAL HEALTH	0	0	0	746,650	0.000000 93.00
200.00		Total (lines 50 through 199)	0	0	0	488,865,282	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 3/31/2025 9:29 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		4,078,636	0	20,411,586	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		202,375	0	1,653,164	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		960,677	0	1,368	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		207,485	0	1,169,136	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		204,350	0	1,687,131	0	54.00
54.01	03630	ULTRA SOUND	0.000000		74,076	0	943,575	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		0	0	637,091	0	54.02
57.00	05700	CT SCAN	0.000000		846,114	0	6,138,473	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		133,987	0	2,201,856	0	58.00
60.00	06000	LABORATORY	0.000000		877,002	0	2,274,974	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		54,699	0	110,291	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		79,502	0	612,584	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		1,230,966	0	591,280	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		136,124	0	27,781	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		128,537	0	71,544	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		44,852	0	5,607	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		332,789	0	990,005	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		599,137	0	1,150,649	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		825,869	0	1,697,734	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		847,346	0	8,717,974	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.000000		5,552	0	493,711	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000		0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000		0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT	0.000000		0	0	208,083	0	76.03
76.04	03610	SLEEP LAB	0.000000		0	0	491,145	0	76.04
76.05	03480	ONCOLOGY	0.000000		1,791	0	3,264,812	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	69,496	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON	0.000000		0	0	0	0	88.00
88.01	08801	RHC II BROWSTOWN	0.000000		0	0	0	0	88.01
88.02	08802	RHC III OBGYN	0.000000		0	0	0	0	88.02
88.03	08803	RHC IV URGENT CARE	0.000000		0	0	0	0	88.03
88.04	08804	RHC V SPC IM PEDS	0.000000		0	0	0	0	88.04
88.05	08805	RHC VI JENNINGS	0.000000		0	0	0	0	88.05
88.06	08806	RHC VII SCOTT	0.000000		0	0	0	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000		0	0	0	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0.000000		0	0	0	0	88.08
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000		0	0	0	0	90.01
90.02	09002	VEIN CENTER	0.000000		0	0	531,029	0	90.02
90.03	09003	OBGYN	0.000000		0	0	0	0	90.03
90.04	09004	NEUROSURGERY	0.000000		0	0	68,016	0	90.04
90.05	09005	SURGICAL ASSOCIATES	0.000000		0	0	59,706	0	90.05
91.00	09100	EMERGENCY	0.000000		511,133	0	2,653,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		10,338	0	396,148	0	92.00
93.00	04952	BEHAVIORAL HEALTH	0.000000		0	0	0	0	93.00
200.00		Total (lines 50 through 199)			12,393,337	0	59,329,914	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 3/31/2025 9:29 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.115420	20,411,586	0	0	2,355,905	50.00
51.00	05100	RECOVERY ROOM		0.117345	1,653,164	0	0	193,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.198273	1,368	0	0	271	52.00
53.00	05300	ANESTHESIOLOGY		0.010255	1,169,136	0	0	11,989	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.352420	1,687,131	0	0	594,579	54.00
54.01	03630	ULTRA SOUND		0.203211	943,575	0	0	191,745	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0.075371	637,091	0	0	48,018	54.02
57.00	05700	CT SCAN		0.053021	6,138,473	0	0	325,468	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.078624	2,201,856	0	0	173,119	58.00
60.00	06000	LABORATORY		0.243803	2,274,974	0	0	554,645	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.536804	110,291	0	0	59,205	63.00
64.00	06400	INTRAVENOUS THERAPY		0.245712	612,584	0	0	150,519	64.00
65.00	06500	RESPIRATORY THERAPY		0.378861	591,280	0	0	224,013	65.00
66.00	06600	PHYSICAL THERAPY		0.422503	27,781	0	0	11,738	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.213050	71,544	0	0	15,242	67.00
68.00	06800	SPEECH PATHOLOGY		0.282775	5,607	0	0	1,586	68.00
69.00	06900	ELECTROCARDIOLOGY		0.056968	990,005	0	0	56,399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.500223	1,150,649	0	0	575,581	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.822942	1,697,734	0	0	1,397,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.645418	8,717,974	0	1,620	5,626,737	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)		0.536598	493,711	0	0	264,924	76.00
76.01	03953	OTHER ANCILLARY CMS LINE		0.000000	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT		0.000000	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT		1.211014	208,083	0	0	251,991	76.03
76.04	03610	SLEEP LAB		0.222387	491,145	0	0	109,224	76.04
76.05	03480	ONCOLOGY		0.292836	3,264,812	0	0	956,054	76.05
76.97	07697	CARDIAC REHABILITATION		2.027325	69,496	0	0	140,891	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON							88.00
88.01	08801	RHC II BROWSTOWN							88.01
88.02	08802	RHC III OBGYN							88.02
88.03	08803	RHC IV URGENT CARE							88.03
88.04	08804	RHC V SPC IM PEDS							88.04
88.05	08805	RHC VI JENNINGS							88.05
88.06	08806	RHC VII SCOTT							88.06
88.07	08807	RHC VIII WASHINGTON CO							88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE							88.08
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH		0.000000	0	0	0	0	90.01
90.02	09002	VEIN CENTER		0.198500	531,029	0	0	105,409	90.02
90.03	09003	OBGYN		0.000000	0	0	0	0	90.03
90.04	09004	NEUROSURGERY		0.808036	68,016	0	0	54,959	90.04
90.05	09005	SURGICAL ASSOCIATES		4.974309	59,706	0	0	296,996	90.05
91.00	09100	EMERGENCY		0.285825	2,653,965	0	0	758,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		1.756890	396,148	0	0	695,988	92.00
93.00	04952	BEHAVIORAL HEALTH		1.028952	0	0	0	0	93.00
200.00		Subtotal (see instructions)			59,329,914	0	1,620	16,202,893	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			59,329,914	0	1,620	16,202,893	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 3/31/2025 9:29 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,046		73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	0		76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0		76.01
76.02	03951	CASE MANAGEMENT	0	0		76.02
76.03	03950	PAIN MANAGEMENT	0	0		76.03
76.04	03610	SLEEP LAB	0	0		76.04
76.05	03480	ONCOLOGY	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I JACKSON				88.00
88.01	08801	RHC II BROWSTOWN				88.01
88.02	08802	RHC III OBGYN				88.02
88.03	08803	RHC IV URGENT CARE				88.03
88.04	08804	RHC V SPC IM PEDS				88.04
88.05	08805	RHC VI JENNINGS				88.05
88.06	08806	RHC VII SCOTT				88.06
88.07	08807	RHC VIII WASHINGTON CO				88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE				88.08
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PALLIATIVE HEALTH	0	0		90.01
90.02	09002	VEIN CENTER	0	0		90.02
90.03	09003	OBGYN	0	0		90.03
90.04	09004	NEUROSURGERY	0	0		90.04
90.05	09005	SURGICAL ASSOCIATES	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04952	BEHAVIORAL HEALTH	0	0		93.00
200.00		Subtotal (see instructions)	0	1,046		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,046		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 3/31/2025 9:29 am	
				Title XIX		Hospital		Cost	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
						Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.115420	0	0	2,908,306	0	50.00
51.00	05100	RECOVERY ROOM		0.117345	0	0	291,784	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.198273	0	0	71,989	0	52.00
53.00	05300	ANESTHESIOLOGY		0.010255	0	0	197,040	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.352420	0	0	304,314	0	54.00
54.01	03630	ULTRA SOUND		0.203211	0	0	178,171	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0.075371	0	0	29,842	0	54.02
57.00	05700	CT SCAN		0.053021	0	0	886,486	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.078624	0	0	261,124	0	58.00
60.00	06000	LABORATORY		0.243803	0	0	787,053	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.536804	0	0	5,197	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.245712	0	0	38,463	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.378861	0	0	96,370	0	65.00
66.00	06600	PHYSICAL THERAPY		0.422503	0	0	145,194	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.213050	0	0	110,863	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.282775	0	0	49,512	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.056968	0	0	132,177	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.500223	0	0	278,598	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.822942	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.645418	0	0	541,341	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)		0.536598	0	0	46,503	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE		0.000000	0	0	0	0	76.01
76.02	03951	CASE MANAGEMENT		0.000000	0	0	0	0	76.02
76.03	03950	PAIN MANAGEMENT		1.211014	0	0	21,093	0	76.03
76.04	03610	SLEEP LAB		0.222387	0	0	94,392	0	76.04
76.05	03480	ONCOLOGY		0.292836	0	0	188,619	0	76.05
76.97	07697	CARDIAC REHABILITATION		2.027325	0	0	2,696	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON							88.00
88.01	08801	RHC II BROWSTOWN							88.01
88.02	08802	RHC III OBGYN							88.02
88.03	08803	RHC IV URGENT CARE							88.03
88.04	08804	RHC V SPC IM PEDS							88.04
88.05	08805	RHC VI JENNINGS							88.05
88.06	08806	RHC VII SCOTT							88.06
88.07	08807	RHC VIII WASHINGTON CO							88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE							88.08
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	PALLIATIVE HEALTH		0.000000	0	0	0	0	90.01
90.02	09002	VEIN CENTER		0.198500	0	0	54,458	0	90.02
90.03	09003	OBGYN		0.000000	0	0	0	0	90.03
90.04	09004	NEUROSURGERY		0.808036	0	0	9,248	0	90.04
90.05	09005	SURGICAL ASSOCIATES		4.974309	0	0	7,945	0	90.05
91.00	09100	EMERGENCY		0.285825	0	0	1,006,732	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		1.756890	0	0	79,031	0	92.00
93.00	04952	BEHAVIORAL HEALTH		1.028952	0	0	43,106	0	93.00
200.00		Subtotal (see instructions)			0	0	8,867,647	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	0	8,867,647	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0065		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 3/31/2025 9:29 am	
				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	335,677					50.00
51.00	05100	RECOVERY ROOM	0	34,239					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,273					52.00
53.00	05300	ANESTHESIOLOGY	0	2,021					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,246					54.00
54.01	03630	ULTRA SOUND	0	36,206					54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	2,249					54.02
57.00	05700	CT SCAN	0	47,002					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,531					58.00
60.00	06000	LABORATORY	0	191,886					60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	2,790					63.00
64.00	06400	INTRAVENOUS THERAPY	0	9,451					64.00
65.00	06500	RESPIRATORY THERAPY	0	36,511					65.00
66.00	06600	PHYSICAL THERAPY	0	61,345					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	23,619					67.00
68.00	06800	SPEECH PATHOLOGY	0	14,001					68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,530					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,361					71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	349,391					73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0	24,953					76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0	0					76.01
76.02	03951	CASE MANAGEMENT	0	0					76.02
76.03	03950	PAIN MANAGEMENT	0	25,544					76.03
76.04	03610	SLEEP LAB	0	20,992					76.04
76.05	03480	ONCOLOGY	0	55,234					76.05
76.97	07697	CARDIAC REHABILITATION	0	5,466					76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC I JACKSON							88.00
88.01	08801	RHC II BROWSTOWN							88.01
88.02	08802	RHC III OBGYN							88.02
88.03	08803	RHC IV URGENT CARE							88.03
88.04	08804	RHC V SPC IM PEDS							88.04
88.05	08805	RHC VI JENNINGS							88.05
88.06	08806	RHC VII SCOTT							88.06
88.07	08807	RHC VIII WASHINGTON CO							88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE							88.08
90.00	09000	CLINIC	0	0					90.00
90.01	09001	PALLIATIVE HEALTH	0	0					90.01
90.02	09002	VEIN CENTER	0	10,810					90.02
90.03	09003	OBGYN	0	0					90.03
90.04	09004	NEUROSURGERY	0	7,473					90.04
90.05	09005	SURGICAL ASSOCIATES	0	39,521					90.05
91.00	09100	EMERGENCY	0	287,749					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,849					92.00
93.00	04952	BEHAVIORAL HEALTH	0	44,354					93.00
200.00		Subtotal (see instructions)	0	2,096,274					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	2,096,274					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,387	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,335	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)			5,050	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			52	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)			1,127	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)			21	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			266.82	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			266.82	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)			11,632,568	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)			13,875	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)			13,875	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			11,618,693	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)			11,618,693	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)			1,584.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,785,179	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,785,179	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet D-1

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,285,431	2,229	3,268.48	489	1,598,287		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,370,651		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)					6,754,117		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)					449,481		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					250,602		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					700,083		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,054,034		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
55.03	CAR T-cell amount paid as an interim payment					0		55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					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)					5,603		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					5,603		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)					2,285		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,584.01		88.00

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COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/31/2025 9:29 am		
				Title XVIII		Hospital	PPS	
Cost Center Description							1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						3,619,463	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	1,694,421	11,632,568	0.145662	3,619,463	527,218	90.00	
91.00	Nursing Program cost	0	11,632,568	0.000000	3,619,463	0	91.00	
92.00	Allied health cost	0	11,632,568	0.000000	3,619,463	0	92.00	
93.00	All other Medical Education	0	11,632,568	0.000000	3,619,463	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet D-1

Date/Time Prepared:
3/31/2025 9:29 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,387	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,335	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)	5,050	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	52	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)	1,620	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)	2,494	15.00
16.00	Nursery days (title V or XIX only)	1,707	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	266.82	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	266.82	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,549,703	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)	13,875	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)	13,875	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,535,828	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)	11,535,828	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)	1,572.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,547,790	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)	2,547,790	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet D-1

Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Title XIX			Hospital	Cost	
		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)	3,734,527	2,494	1,497.40	1,707	2,556,062	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,250,073	2,229	3,252.61	205	666,785	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,364,995	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)					7,135,632	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
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					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)					2,285	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,572.71	88.00

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COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 3/31/2025 9:29 am		
				Title XIX		Hospital	Cost	
Cost Center Description							1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,593,642	89.00	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost		1,694,421	11,549,703	0.146707	3,593,642	527,212	
91.00	Nursing Program cost		0	11,549,703	0.000000	3,593,642	0	
92.00	Allied health cost		0	11,549,703	0.000000	3,593,642	0	
93.00	All other Medical Education		0	11,549,703	0.000000	3,593,642	0	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/31/2025 9:29 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		2,296,116		30.00
31.00	03100	INTENSIVE CARE UNIT		2,717,393		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.115420	4,078,636	470,756	50.00
51.00	05100	RECOVERY ROOM	0.117345	202,375	23,748	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.198273	960,677	190,476	52.00
53.00	05300	ANESTHESIOLOGY	0.010255	207,485	2,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.352420	204,350	72,017	54.00
54.01	03630	ULTRA SOUND	0.203211	74,076	15,053	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.075371	0	0	54.02
57.00	05700	CT SCAN	0.053021	846,114	44,862	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078624	133,987	10,535	58.00
60.00	06000	LABORATORY	0.245403	877,002	215,219	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.536804	54,699	29,363	63.00
64.00	06400	INTRAVENOUS THERAPY	0.245712	79,502	19,535	64.00
65.00	06500	RESPIRATORY THERAPY	0.378861	1,230,966	466,365	65.00
66.00	06600	PHYSICAL THERAPY	0.422503	136,124	57,513	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.213050	128,537	27,385	67.00
68.00	06800	SPEECH PATHOLOGY	0.282775	44,852	12,683	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056968	332,789	18,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.500223	599,137	299,702	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.822942	825,869	679,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645418	847,346	546,892	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.536598	5,552	2,979	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	0	76.02
76.03	03950	PAIN MANAGEMENT	1.211014	0	0	76.03
76.04	03610	SLEEP LAB	0.222387	0	0	76.04
76.05	03480	ONCOLOGY	0.324896	1,791	582	76.05
76.97	07697	CARDIAC REHABILITATION	2.027325	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I JACKSON	0.000000		0	88.00
88.01	08801	RHC II BROWSTOWN	0.000000		0	88.01
88.02	08802	RHC III OBGYN	0.000000		0	88.02
88.03	08803	RHC IV URGENT CARE	0.000000		0	88.03
88.04	08804	RHC V SPC IM PEDS	0.000000		0	88.04
88.05	08805	RHC VI JENNINGS	0.000000		0	88.05
88.06	08806	RHC VII SCOTT	0.000000		0	88.06
88.07	08807	RHC VIII WASHINGTON CO	0.000000		0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0.000000		0	88.08
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	0	90.01
90.02	09002	VEIN CENTER	0.200635	0	0	90.02
90.03	09003	OBGYN	0.000000	0	0	90.03
90.04	09004	NEUROSURGERY	0.808036	0	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.978260	0	0	90.05
91.00	09100	EMERGENCY	0.285825	511,133	146,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.756890	10,338	18,163	92.00
93.00	04952	BEHAVIORAL HEALTH	1.028952	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,393,337	3,370,651	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		12,393,337		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3	
		Component CCN: 15-U065		Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.115420	0	0	50.00
51.00	05100 RECOVERY ROOM	0.117345	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.198273	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.010255	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.352420	984	347	54.00
54.01	03630 ULTRA SOUND	0.203211	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.075371	0	0	54.02
57.00	05700 CT SCAN	0.053021	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.078624	0	0	58.00
60.00	06000 LABORATORY	0.245403	5,160	1,266	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.536804	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.245712	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.378861	15,304	5,798	65.00
66.00	06600 PHYSICAL THERAPY	0.422503	4,290	1,813	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.213050	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.282775	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.056968	2,635	150	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.500223	2,553	1,277	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.822942	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.645418	9,498	6,130	73.00
76.00	03952 WOUND CARE (DIABETES CENTER)	0.536598	0	0	76.00
76.01	03953 OTHER ANCILLARY CMS LINE	0.000000	0	0	76.01
76.02	03951 CASE MANAGEMENT	0.000000	0	0	76.02
76.03	03950 PAIN MANAGEMENT	1.211014	0	0	76.03
76.04	03610 SLEEP LAB	0.222387	0	0	76.04
76.05	03480 ONCOLOGY	0.324896	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	2.027325	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC I JACKSON	0.000000		0	88.00
88.01	08801 RHC II BROWSTOWN	0.000000		0	88.01
88.02	08802 RHC III OBGYN	0.000000		0	88.02
88.03	08803 RHC IV URGENT CARE	0.000000		0	88.03
88.04	08804 RHC V SPC IM PEDS	0.000000		0	88.04
88.05	08805 RHC VI JENNINGS	0.000000		0	88.05
88.06	08806 RHC VII SCOTT	0.000000		0	88.06
88.07	08807 RHC VIII WASHINGTON CO	0.000000		0	88.07
88.08	08808 RHC IX PEDS & ADULT MEDICINE	0.000000		0	88.08
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 PALLIATIVE HEALTH	0.000000	0	0	90.01
90.02	09002 VEIN CENTER	0.200635	0	0	90.02
90.03	09003 OBGYN	0.000000	0	0	90.03
90.04	09004 NEUROSURGERY	0.808036	0	0	90.04
90.05	09005 SURGICAL ASSOCIATES	4.978260	0	0	90.05
91.00	09100 EMERGENCY	0.285825	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.756890	0	0	92.00
93.00	04952 BEHAVIORAL HEALTH	1.028952	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		40,424	16,781	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		40,424		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 3/31/2025 9:29 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,567,947	30.00
31.00	03100	INTENSIVE CARE UNIT		513,563	31.00
43.00	04300	NURSERY		3,998,229	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.115420	657,484	50.00
51.00	05100	RECOVERY ROOM	0.117345	49,316	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.198273	3,226,894	52.00
53.00	05300	ANESTHESIOLOGY	0.010255	98,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.352420	28,412	54.00
54.01	03630	ULTRA SOUND	0.203211	52,325	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.075371	0	54.02
57.00	05700	CT SCAN	0.053021	90,729	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078624	17,322	58.00
60.00	06000	LABORATORY	0.243803	807,131	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.536804	22,546	63.00
64.00	06400	INTRAVENOUS THERAPY	0.245712	16,115	64.00
65.00	06500	RESPIRATORY THERAPY	0.378861	261,298	65.00
66.00	06600	PHYSICAL THERAPY	0.422503	23,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.213050	13,754	67.00
68.00	06800	SPEECH PATHOLOGY	0.282775	31,624	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056968	65,687	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.500223	104,514	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.822942	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645418	299,847	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.536598	4,239	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	76.02
76.03	03950	PAIN MANAGEMENT	1.211014	0	76.03
76.04	03610	SLEEP LAB	0.222387	0	76.04
76.05	03480	ONCOLOGY	0.292836	0	76.05
76.97	07697	CARDIAC REHABILITATION	2.027325	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0.000000	0	88.00
88.01	08801	RHC II BROWSTOWN	1.084898	0	88.01
88.02	08802	RHC III OBGYN	0.656407	0	88.02
88.03	08803	RHC IV URGENT CARE	1.556502	0	88.03
88.04	08804	RHC V SPC IM PEDS	1.370278	0	88.04
88.05	08805	RHC VI JENNINGS	1.937730	0	88.05
88.06	08806	RHC VII SCOTT	1.320115	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	1.676622	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0.849652	0	88.08
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	90.01
90.02	09002	VEIN CENTER	0.198500	0	90.02
90.03	09003	OBGYN	0.000000	0	90.03
90.04	09004	NEUROSURGERY	0.808036	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.974309	0	90.05
91.00	09100	EMERGENCY	0.285825	105,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.756890	0	92.00
93.00	04952	BEHAVIORAL HEALTH	1.028952	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,976,540	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)		5,976,540	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3
			Component CCN: 15-U065		Date/Time Prepared: 3/31/2025 9:29 am
			Title XIX	Swing Beds - NF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.115420	0	50.00
51.00	05100	RECOVERY ROOM	0.117345	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.198273	0	52.00
53.00	05300	ANESTHESIOLOGY	0.010255	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.352420	0	54.00
54.01	03630	ULTRA SOUND	0.203211	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.075371	0	54.02
57.00	05700	CT SCAN	0.053021	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078624	0	58.00
60.00	06000	LABORATORY	0.243803	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.536804	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.245712	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.378861	0	65.00
66.00	06600	PHYSICAL THERAPY	0.422503	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.213050	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.282775	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056968	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.500223	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.822942	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645418	0	73.00
76.00	03952	WOUND CARE (DIABETES CENTER)	0.536598	0	76.00
76.01	03953	OTHER ANCILLARY CMS LINE	0.000000	0	76.01
76.02	03951	CASE MANAGEMENT	0.000000	0	76.02
76.03	03950	PAIN MANAGEMENT	1.211014	0	76.03
76.04	03610	SLEEP LAB	0.222387	0	76.04
76.05	03480	ONCOLOGY	0.292836	0	76.05
76.97	07697	CARDIAC REHABILITATION	2.027325	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I JACKSON	0.000000	0	88.00
88.01	08801	RHC II BROWSTOWN	1.084898	0	88.01
88.02	08802	RHC III OBGYN	0.656407	0	88.02
88.03	08803	RHC IV URGENT CARE	1.556502	0	88.03
88.04	08804	RHC V SPC IM PEDS	1.370278	0	88.04
88.05	08805	RHC VI JENNINGS	1.937730	0	88.05
88.06	08806	RHC VII SCOTT	1.320115	0	88.06
88.07	08807	RHC VIII WASHINGTON CO	1.676622	0	88.07
88.08	08808	RHC IX PEDS & ADULT MEDICINE	0.849652	0	88.08
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PALLIATIVE HEALTH	0.000000	0	90.01
90.02	09002	VEIN CENTER	0.198500	0	90.02
90.03	09003	OBGYN	0.000000	0	90.03
90.04	09004	NEUROSURGERY	0.808036	0	90.04
90.05	09005	SURGICAL ASSOCIATES	4.974309	0	90.05
91.00	09100	EMERGENCY	0.285825	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.756890	0	92.00
93.00	04952	BEHAVIORAL HEALTH	1.028952	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 3/31/2025 9:29 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,133,572	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,191,758	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		178,413	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		29,102	2.04
3.00	Managed Care Simulated Payments		1,513,738	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		51.61	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
8.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)			8.28
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.28 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.08	30.00
31.00	Percentage of Medicaid patient days (see instructions)		40.67	31.00
32.00	Sum of lines 30 and 31		44.75	32.00

3/31/2025 9:29 am

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	Hospital	PPS	
				1.00	
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			129,760	34.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		944,511	800,066	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		707,093	201,661	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		908,754		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		5,571,359		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			5,571,359	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			360,742	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			5,932,101	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,932,101	61.00
62.00	Deductibles billed to program beneficiaries			489,566	62.00
63.00	Coinsurance billed to program beneficiaries			4,080	63.00
64.00	Allowable bad debts (see instructions)			104,187	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			67,722	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			24,312	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5,506,177	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.76	Essential medicines payment adjustment amount (see instructions)				70.76
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			26,777	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2024	575,650	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2025	202,390	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,310,994	71.00
71.01	Sequestration adjustment (see instructions)		126,220	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		5,957,426	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		227,348	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		501,094	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,133,572	0	3,133,572		3,133,572
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,191,758	0		1,191,758	1,191,758
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	178,413	0	178,413		178,413
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,102	0		29,102	29,102
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	1,513,738	0	1,412,984	100,754	1,513,738
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	129,760	0	94,007	35,753	129,760
11.01	Uncompensated care payments	36.00	908,754	0	707,093	201,661	908,754
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	5,571,359	0	4,113,085	1,458,274	5,571,359
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,571,359	0	4,113,085	1,458,274	5,571,359
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	360,742	0	263,986	96,756	360,742

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LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	4,377,071	1,555,030	5,932,101
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	334,280	0	242,144	92,136	334,280
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	26,462	0	21,842	4,620	26,462
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	360,742	0	263,986	96,756	360,742
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.131515	0.130152	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			575,650		575,650
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				202,390	202,390
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,133,572	3,133,572		3,133,572	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,191,758		1,191,758	1,191,758	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	178,413	178,413		178,413	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29,102		29,102	29,102	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,513,738	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	129,760	94,007	35,753	129,760	11.00
11.01	Uncompensated care payments	36.00	908,754	707,093	201,632	908,725	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,571,359	4,113,114	1,458,245	5,571,359	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,571,359	4,113,114	1,458,245	5,571,359	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	360,742	263,986	96,756	360,742	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,377,100	1,555,001	5,932,101	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	334,280	242,144	92,136	334,280	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	26,462	21,842	4,620	26,462	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	360,742	263,986	96,756	360,742	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	575,650	575,650		575,650	28.00
29.00	Low volume adjustment on or after October 1	70.97	202,390		202,390	202,390	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	26,777	16,881	9,896	26,777	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 3/31/2025 9:29 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,046	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,202,893	2.00
3.00	OPPS or REH payments		14,720,860	3.00
4.00	Outlier payment (see instructions)		304,527	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)		1,046	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,620	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)		1,620	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)		1,620	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		574	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)		1,046	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)		15,025,387	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,599,540	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)		12,426,893	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)		12,426,893	30.00
31.00	Primary payer payments		13,546	31.00
32.00	Subtotal (line 30 minus line 31)		12,413,347	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)		270,637	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		175,914	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		93,065	36.00
37.00	Subtotal (see instructions)		12,589,261	37.00
38.00	MSP-LCC reconciliation amount from PS&R		60	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)		12,589,201	40.00
40.01	Sequestration adjustment (see instructions)		251,784	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		12,317,277	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)		20,140	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		94,723	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

3/31/2025 9:29 am

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	Hospital	PPS	
					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: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E-1
Part I
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Hospital		PPS
		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		5,957,426		12,255,477	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	10/04/2024	61,800	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		61,800	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)		5,957,426		12,317,277	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		227,348		20,140	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,184,774		12,337,417	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: 15-0065

Period:

Worksheet E-1

Component CCN: 15-U065

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		Swing Beds - SNF		PPS
		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		8,359		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)		8,359		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,359		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: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet E-1
Part II
Date/Time Prepared:
3/31/2025 9:29 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0065

Period:

Worksheet E-2

Component CCN: 15-U065

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII	Swing Beds - SNF	PPS	
			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)		8,530	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)		0	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		21	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)		8,530	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		8,530	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)		8,530	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)		8,530	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)		8,530	0	19.00
19.01	Sequestration adjustment (see instructions)		171	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		8,359	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)		0	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 - SWING BEDS

Provider CCN: 15-0065

Period:

Worksheet E-2

Component CCN: 15-U065

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XIX	Swing Beds - NF	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)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		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)		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		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)		0		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0		11.00
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0		13.00
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (see instructions)		0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		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)				16.55
16.99	Demonstration payment adjustment amount before sequestration		0		16.99
17.00	Allowable bad debts (see instructions)		0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		18.00
19.00	Total (see instructions)		0		19.00
19.01	Sequestration adjustment (see instructions)		0		19.01
19.02	Demonstration payment adjustment amount after sequestration)		0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0		19.25
20.00	Interim payments		0		20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		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)		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		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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet E-5	
		Title XVIII		Date/Time Prepared: 3/31/2025 9:29 am	
				PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0	4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	Time value of money for capital related expenses (see instructions)			0	7.00

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

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet G

Date/Time Prepared:
3/31/2025 9:29 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	63,987,204	0	0	0	1.00
2.00 Temporary investments	25,000,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	84,538,546	0	0	0	4.00
5.00 Other receivable	11,117,378	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-62,559,918	0	0	0	6.00
7.00 Inventory	5,846,433	0	0	0	7.00
8.00 Prepaid expenses	3,190,335	0	0	0	8.00
9.00 Other current assets	87,935,710	0	0	0	9.00
10.00 Due from other funds	-12,290,767	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	206,764,921	0	0	0	11.00
FIXED ASSETS					
12.00 Land	12,746,994	0	0	0	12.00
13.00 Land improvements	4,889,493	0	0	0	13.00
14.00 Accumulated depreciation	-3,453,091	0	0	0	14.00
15.00 Buildings	162,751,408	0	0	0	15.00
16.00 Accumulated depreciation	-83,633,596	0	0	0	16.00
17.00 Leasehold improvements	7,070,516	0	0	0	17.00
18.00 Accumulated depreciation	-94,659	0	0	0	18.00
19.00 Fixed equipment	12,062,120	0	0	0	19.00
20.00 Accumulated depreciation	-6,557,459	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	69,924,563	0	0	0	23.00
24.00 Accumulated depreciation	-49,419,934	0	0	0	24.00
25.00 Minor equipment depreciable	11,791,711	0	0	0	25.00
26.00 Accumulated depreciation	-9,256,526	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)	128,821,540	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	8,079,409	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	206,152,255	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	214,231,664	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	549,818,125	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,334,450	0	0	0	37.00
38.00 Salaries, wages, and fees payable	19,809,905	0	0	0	38.00
39.00 Payroll taxes payable	58,886	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,030,671	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	25,233,912	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	21,228,657	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	18,369,481	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	39,598,138	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	64,832,050	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	484,986,075				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)	484,986,075	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	549,818,125	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-1

Date/Time Prepared:
3/31/2025 9:29 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		462,248,012		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		22,738,063				2.00
3.00	Total (sum of line 1 and line 2)		484,986,075		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)		484,986,075		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)		484,986,075		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: 15-0065

Period:
From 01/01/2024
To 12/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,901,806		12,901,806	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,901,806		12,901,806	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,857,331		8,857,331	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)	8,857,331		8,857,331	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,759,137		21,759,137	17.00
18.00	Ancillary services	61,269,165	402,597,093	463,866,258	18.00
19.00	Outpatient services	4,788,255	41,142,983	45,931,238	19.00
20.00	RHC I JACKSON	0	0	0	20.00
20.01	RHC II BROWSTOWN	0	826,354	826,354	20.01
20.02	RHC III OBGYN	2,182,615	5,424,341	7,606,956	20.02
20.03	RHC IV URGENT CARE	0	1,268,095	1,268,095	20.03
20.04	RHC V SPC IM PEDS	0	6,012,424	6,012,424	20.04
20.05	RHC VI JENNINGS	0	918,936	918,936	20.05
20.06	RHC VII SCOTT	0	1,615,962	1,615,962	20.06
20.07	RHC VIII WASHINGTON CO	0	785,007	785,007	20.07
20.08	RHC IX PEDS & ADULT MEDICINE	0	0	0	20.08
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,593,045	2,593,045	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,352,038	2,352,038	26.00
27.00	OTHER OUTPATIENT	1,048,858	26,419,937	27,468,795	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	91,048,030	491,956,215	583,004,245	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		214,888,092		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)		214,888,092		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0065

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-3

Date/Time Prepared:
3/31/2025 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	583,004,245	1.00
2.00	Less contractual allowances and discounts on patients' accounts	363,678,190	2.00
3.00	Net patient revenues (line 1 minus line 2)	219,326,055	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	214,888,092	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,437,963	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	348,549	6.00
7.00	Income from investments	18,400,707	7.00
8.00	Revenues from telephone and other miscellaneous communication services	1,946	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	93,117	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	648,231	14.00
15.00	Revenue from rental of living quarters	634,015	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	389,318	17.00
18.00	Revenue from sale of medical records and abstracts	15,176	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	5,400	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	89,393	22.00
23.00	Governmental appropriations	0	23.00
24.00	CONTRACT REVENUE	297,806	24.00
24.01	GRANT REVENUE	1,951,980	24.01
24.02	MISCELLANEOUS INCOME	-4,590,882	24.02
24.03	UNREALIZED GAIN/LOSS	15,344	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	18,300,100	25.00
26.00	Total (line 5 plus line 25)	22,738,063	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)	22,738,063	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0065

Period:

Worksheet H

HHA CCN: 15-7155

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

3/31/2025 9:29 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	432,594	0	0	10,986	105,123	548,703	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	886,683	0	0	0	0	886,683	6.00
7.00 Physical Therapy	294,288	0	0	0	0	294,288	7.00
8.00 Occupational Therapy	243,597	0	0	0	0	243,597	8.00
9.00 Speech Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Home Health Aide	47,595	0	0	0	0	47,595	11.00
12.00 Supplies (see instructions)	0	0	0	0	12,001	12,001	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	1,904,757	0	0	10,986	117,124	2,032,867	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	0	548,703	-127,616	421,087			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	886,683	0	886,683			6.00
7.00 Physical Therapy	0	294,288	0	294,288			7.00
8.00 Occupational Therapy	-5,700	237,897	0	237,897			8.00
9.00 Speech Pathology	5,700	5,700	0	5,700			9.00
10.00 Medical Social Services	0	0	493	493			10.00
11.00 Home Health Aide	0	47,595	0	47,595			11.00
12.00 Supplies (see instructions)	0	12,001	0	12,001			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	0	2,032,867	-127,123	1,905,744			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.
3/31/2025 9:29 am

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0065

Period:

Worksheet H-1

HHA CCN: 15-7155

From 01/01/2024

Part I

To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

Home Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
									0
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	421,087	0	0	0	0	421,087	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	886,683	0	0	0	0	886,683	6.00	
7.00	Physical Therapy	294,288	0	0	0	0	294,288	7.00	
8.00	Occupational Therapy	237,897	0	0	0	0	237,897	8.00	
9.00	Speech Pathology	5,700	0	0	0	0	5,700	9.00	
10.00	Medical Social Services	493	0	0	0	0	493	10.00	
11.00	Home Health Aide	47,595	0	0	0	0	47,595	11.00	
12.00	Supplies (see instructions)	12,001	0	0	0	0	12,001	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	1,905,744	0	0	0	0	1,905,744	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	421,087						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	251,485	1,138,168					6.00	
7.00	Physical Therapy	83,468	377,756					7.00	
8.00	Occupational Therapy	67,474	305,371					8.00	
9.00	Speech Pathology	1,617	7,317					9.00	
10.00	Medical Social Services	140	633					10.00	
11.00	Home Health Aide	13,499	61,094					11.00	
12.00	Supplies (see instructions)	3,404	15,405					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		1,905,744					24.00	

3/31/2025 9:29 am

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet H-1

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	1,579				0		1.00
2.00	Capital Related - Movable Equipment		274			0		2.00
3.00	Plant Operation & Maintenance	0	0	1,579		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	1,579	274	1,579	0	-421,087	1,484,657	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	886,683	6.00
7.00	Physical Therapy	0	0	0	0	0	294,288	7.00
8.00	Occupational Therapy	0	0	0	0	0	237,897	8.00
9.00	Speech Pathology	0	0	0	0	0	5,700	9.00
10.00	Medical Social Services	0	0	0	0	0	493	10.00
11.00	Home Health Aide	0	0	0	0	0	47,595	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12,001	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,579	274	1,579	0	-421,087	1,484,657	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		421,087	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.283626	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0065

Period:

Worksheet H-2

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	37,982	317	91,358	129,657	23,492	1.00
2.00	Skilled Nursing Care	1,138,168	0	0	269,624	1,407,792	255,074	2.00
3.00	Physical Therapy	377,756	0	0	89,487	467,243	84,659	3.00
4.00	Occupational Therapy	305,371	0	0	74,073	379,444	68,751	4.00
5.00	Speech Pathology	7,317	0	0	0	7,317	1,326	5.00
6.00	Medical Social Services	633	0	0	150	783	142	6.00
7.00	Home Health Aide	61,094	0	0	14,473	75,567	13,692	7.00
8.00	Supplies (see instructions)	15,405	0	0	0	15,405	2,791	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,905,744	37,982	317	539,165	2,483,208	449,927	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	37,976	0	11,813	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	37,976	0	11,813	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
3/31/2025 9:29 am

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0065

Period:

Worksheet H-2

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE PHYSICIAN PRIVATE PRACTICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	18.00	19.00	24.00	
1.00	Administrative and General	0	0	10,686	0	0	213,624	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,662,866	2.00
3.00	Physical Therapy	0	0	0	0	0	551,902	3.00
4.00	Occupational Therapy	0	0	0	0	0	448,195	4.00
5.00	Speech Pathology	0	0	0	0	0	8,643	5.00
6.00	Medical Social Services	0	0	0	0	0	925	6.00
7.00	Home Health Aide	0	0	0	0	0	89,259	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	18,196	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	10,686	0	0	2,993,610	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	213,624					1.00
2.00	Skilled Nursing Care	0	1,662,866	127,781	1,790,647			2.00
3.00	Physical Therapy	0	551,902	42,410	594,312			3.00
4.00	Occupational Therapy	0	448,195	34,441	482,636			4.00
5.00	Speech Pathology	0	8,643	664	9,307			5.00
6.00	Medical Social Services	0	925	71	996			6.00
7.00	Home Health Aide	0	89,259	6,859	96,118			7.00
8.00	Supplies (see instructions)	0	18,196	1,398	19,594			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	2,993,610	213,624	2,993,610			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.076844				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
3/31/2025 9:29 am

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet H-2

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			Reconciliation	Agency 1	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)		
						1.00		
1.00	Administrative and General	1,579	274	300,441	0	129,657	1,579	1.00
2.00	Skilled Nursing Care	0	0	886,683	0	1,407,792	0	2.00
3.00	Physical Therapy	0	0	294,288	0	467,243	0	3.00
4.00	Occupational Therapy	0	0	243,597	0	379,444	0	4.00
5.00	Speech Pathology	0	0	0	0	7,317	0	5.00
6.00	Medical Social Services	0	0	493	0	783	0	6.00
7.00	Home Health Aide	0	0	47,595	0	75,567	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	15,405	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,579	274	1,773,097		2,483,208	1,579	20.00
21.00	Total cost to be allocated	37,982	317	539,165		449,927	37,976	21.00
22.00	Unit cost multiplier	24.054465	1.156934	0.304081		0.181188	24.050665	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,579	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,579	0	0	0	0	20.00
21.00	Total cost to be allocated	0	11,813	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	7.481317	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet H-2

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 amHome Health
Agency I

PPS

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
				PHYSICIAN PRIVATE PRACTICE (TIME SPENT)			
				15.00			
1.00	Administrative and General	0	2,593,045	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	2,593,045	0	0		20.00
21.00	Total cost to be allocated	0	10,686	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.004121	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet H-3

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 am

				Title XVIII		Home Health Agency I	PPS			
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	2.00	1,790,647		1,790,647	3,550	504.41	1.00		
2.00	Physical Therapy	3.00	594,312	0	594,312	2,810	211.50	2.00		
3.00	Occupational Therapy	4.00	482,636	0	482,636	1,501	321.54	3.00		
4.00	Speech Pathology	5.00	9,307	0	9,307	57	163.28	4.00		
5.00	Medical Social Services	6.00	996		996	15	66.40	5.00		
6.00	Home Health Aide	7.00	96,118		96,118	515	186.64	6.00		
7.00	Total (sum of lines 1-6)		2,974,016	0	2,974,016	8,448		7.00		
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits					
					Part B					
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation										
8.00	Skilled Nursing Care		18020	0	28			8.00		
8.01	Skilled Nursing Care		31140	0	94			8.01		
8.02	Skilled Nursing Care		99915	0	934			8.02		
9.00	Physical Therapy		18020	0	53			9.00		
9.01	Physical Therapy		31140	0	30			9.01		
9.02	Physical Therapy		99915	0	818			9.02		
10.00	Occupational Therapy		18020	0	30			10.00		
10.01	Occupational Therapy		31140	0	7			10.01		
10.02	Occupational Therapy		99915	0	455			10.02		
11.00	Speech Pathology		18020	0	0			11.00		
11.01	Speech Pathology		31140	0	0			11.01		
11.02	Speech Pathology		99915	0	9			11.02		
12.00	Medical Social Services		18020	0	0			12.00		
12.01	Medical Social Services		31140	0	0			12.01		
12.02	Medical Social Services		99915	0	5			12.02		
13.00	Home Health Aide		18020	0	0			13.00		
13.01	Home Health Aide		31140	0	0			13.01		
13.02	Home Health Aide		99915	0	182			13.02		
14.00	Total (sum of lines 8-13)			0	2,645			14.00		
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)			
		0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations										
15.00	Cost of Medical Supplies	8.00	19,594	0	19,594	45,453	0.431083	15.00		
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00		
Cost Center Description		Program Visits			Cost of Services					
		Part A	Part B		Part A	Part B	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance					Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
6.00	7.00	8.00	9.00	10.00	11.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	0	1,056		0	532,657		1.00		
2.00	Physical Therapy	0	901		0	190,562		2.00		
3.00	Occupational Therapy	0	492		0	158,198		3.00		
4.00	Speech Pathology	0	9		0	1,470		4.00		
5.00	Medical Social Services	0	5		0	332		5.00		
6.00	Home Health Aide	0	182		0	33,968		6.00		
7.00	Total (sum of lines 1-6)	0	2,645		0	917,187		7.00		

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet H-3

HHA CCN: 15-7155

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
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Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	31,304	0	0	13,495	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	532,657						1.00
2.00	Physical Therapy	190,562						2.00
3.00	Occupational Therapy	158,198						3.00
4.00	Speech Pathology	1,470						4.00
5.00	Medical Social Services	332						5.00
6.00	Home Health Aide	33,968						6.00
7.00	Total (sum of lines 1-6)	917,187						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet H-3

HHA CCN: 15-7155

From 01/01/2024

Part II

To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.422503	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.213050	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.282775	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.500223	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.645418	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0065 HHA CCN: 15-7155	Period: From 01/01/2024 To 12/31/2024	Worksheet H-4 Part I-II Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	724,025	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	14,831	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	12,763	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	433	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,786	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	754,838	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	754,838	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	754,838	26.00
27.00	Allowable bad debts (from your records)			0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)			0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)			0	28.00
29.00	Total costs - current cost reporting period (see instructions)		0	754,838	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	754,838	31.00
31.01	Sequestration adjustment (see instructions)		0	15,097	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0	31.75
32.00	Interim payments (see instructions)		0	739,741	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

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

Provider CCN: 15-0065

Period:

Worksheet H-5

HHA CCN: 15-7155

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

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Home Health
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PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		739,741	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		739,741	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		739,741	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	46,684	46,684	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	5,248	5,248	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,215	2,215	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	4,343	13.00
14.00	PHARMACY*	0	268	268	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	8,328	8,328	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	49,321	0	49,321	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	27.00
28.00	REGISTERED NURSE**	374,168	0	374,168	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	87,068	33.00
34.00	SPIRITUAL COUNSELING**	135,016	0	135,016	-91,410	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	108,426	0	108,426	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	62,755	62,755	0	38.00
39.00	PATIENT TRANSPORTATION**	0	11,000	11,000	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	1,486	1,486	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	340	340	-1	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	666,931	138,324	805,255	0	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	13,507	60,191	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	5,248	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	69,609	69,609	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	2,215	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	4,343	13.00
14.00	PHARMACY*	0	268	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	8,328	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	49,321	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	374,168	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	87,068	33.00
34.00	SPIRITUAL COUNSELING**	0	43,606	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	108,426	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	62,755	38.00
39.00	PATIENT TRANSPORTATION**	0	11,000	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	1,486	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	339	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	83,116	888,371	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0065

Period:

Worksheet 0-2

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	48,389	0	48,389	0	48,389	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	367,100	0	367,100	0	367,100	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	85,423	85,423	33.00
34.00	SPIRITUAL COUNSELING	132,465	0	132,465	-89,684	42,781	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	106,378	0	106,378	0	106,378	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	62,755	62,755	0	62,755	38.00
39.00	PATIENT TRANSPORTATION	0	10,792	10,792	0	10,792	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1,458	1,458	0	1,458	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	654,332	75,005	729,337	-4,261	725,076	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	48,389	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	367,100	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	85,423	33.00
34.00	SPIRITUAL COUNSELING	0	42,781	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	106,378	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	62,755	38.00
39.00	PATIENT TRANSPORTATION	0	10,792	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1,458	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	725,076	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 15-0065

Period:

Worksheet 0-3

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

				Hospice I		07/01/2025 01:25 AM	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	553	0	553	0	553	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	4,193	0	4,193	0	4,193	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	976	976	33.00
34.00	SPIRITUAL COUNSELING	1,513	0	1,513	-1,024	489	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,215	0	1,215	0	1,215	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	123	123	0	123	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	17	17	0	17	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	7,474	140	7,614	-48	7,566	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	553	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	4,193	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	976	33.00
34.00	SPIRITUAL COUNSELING	0	489	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	1,215	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	123	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	17	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	7,566	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 15-0065

Period:

Worksheet 0-4

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	379	0	379	0	379	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	2,875	0	2,875	0	2,875	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	669	669	33.00
34.00	SPIRITUAL COUNSELING	1,038	0	1,038	-702	336	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	833	0	833	0	833	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	85	85	0	85	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	11	11	0	11	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	5,125	96	5,221	-33	5,188	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	379	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	2,875	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	669	33.00
34.00	SPIRITUAL COUNSELING	0	336	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	833	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	85	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	11	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	5,188	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 15-0065

Period:

Worksheet 0-5

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	37,982	37,982	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	227,636	227,636	3.00
4.00	ADMINISTRATIVE & GENERAL	60,191	209,089	269,280	4.00
5.00	PLANT OPERATION & MAINTENANCE	5,248	37,976	43,224	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	11,813	11,813	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	69,609	0	69,609	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,215	0	2,215	10.00
11.00	MEDICAL RECORDS	0	9,693	9,693	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	4,343	0	4,343	13.00
14.00	PHARMACY	268	0	268	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	8,328	0	8,328	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	725,076	0	725,076	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,566	0	7,566	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	5,188	0	5,188	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	339	0	339	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	888,371	534,189	1,422,560	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	37,982	37,982					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	227,636	0	0	227,636			3.00
4.00	ADMINISTRATIVE & GENERAL	269,280	7,133	0	3,950	280,363		4.00
5.00	PLANT OPERATION & MAINTENANCE	43,224	0	0	0	43,224		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0		6.00
7.00	HOUSEKEEPING	11,813	0	0	0	11,813		7.00
8.00	DIETARY	0	0	0	0	0		8.00
9.00	NURSING ADMINISTRATION	69,609	2,350	0	21,140	93,099		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,215	986	0	0	3,201		10.00
11.00	MEDICAL RECORDS	9,693	0	0	0	9,693		11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	4,343	0	0	0	4,343		13.00
14.00	PHARMACY	268	0	0	0	268		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	10,273	0	0	10,273		15.00
16.00	OTHER GENERAL SERVICE	8,328	4,700	0	0	13,028		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		3,501	0		3,501		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	725,076			198,720	923,796		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,566	0	0	2,270	9,836		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	5,188	0	0	1,556	6,744		53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	9,039	0	0	9,039		60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0		61.00
62.00	FUNDRAISING	0	0	0	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0		66.00
67.00	ADVERTISING	339	0	0	0	339		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0		68.00
69.00	THRIFT STORE	0	0	0	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0		71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0		99.00
100.00	TOTAL	1,422,560	37,982	0	227,636	1,422,560		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024

Part I

To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	280,363						4.00
5.00	PLANT OPERATION & MAINTENANCE	10,610	53,834					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	2,900	0			14,713		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	22,852	4,101			1,121		9.00
10.00	ROUTINE MEDICAL SUPPLIES	786	1,721			470		10.00
11.00	MEDICAL RECORDS	2,379	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	1,066	0			0		13.00
14.00	PHARMACY	66	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	2,522	17,926			4,899		15.00
16.00	OTHER GENERAL SERVICE	3,198	8,203			2,242		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	859	6,109			1,670		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	226,754						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,414	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,655	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	2,219	15,774			4,311		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	83	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	280,363	53,834		0	14,713	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 am

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	121,173					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	6,178				10.00
11.00	MEDICAL RECORDS	0		12,072			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	5,409	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	5,409	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	36,352	6,062	11,844	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	36,352	69	135	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	36,352	47	93	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	12,117			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	121,173	6,178	12,072	0	5,409	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
3/31/2025 9:29 am

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	334					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	35,620				15.00
16.00	OTHER GENERAL SERVICE	334		32,414			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				12,139		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	34,947	31,802		1,271,557	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	399	363	7,201	56,769	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	274	249	4,938	50,352	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		43,460	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		422	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	334	35,620	32,414	12,139	1,422,560	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,311					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	749,547			3.00
4.00	ADMINISTRATIVE & GENERAL	434	0	13,007	-280,363	1,142,197	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	43,224	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	11,813	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	143	0	69,609	0	93,099	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60	0	0	0	3,201	10.00
11.00	MEDICAL RECORDS	0	0	0	0	9,693	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	4,343	13.00
14.00	PHARMACY	0	0	0	0	268	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625	0	0	0	10,273	15.00
16.00	OTHER GENERAL SERVICE	286	0	0	0	13,028	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	213	0	0	0	3,501	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			654,332	0	923,796	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	7,474	0	9,836	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	5,125	0	6,744	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	550	0	0	0	9,039	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	339	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	37,982	0	227,636		280,363	100.00
101.00	UNIT COST MULTIPLIER	16.435309	0.000000	0.303698		0.245459	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,877					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1,877			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	143		143		100	9.00
10.00	ROUTINE MEDICAL SUPPLIES	60		60		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	625		625		0	15.00
16.00	OTHER GENERAL SERVICE	286		286		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	213		213			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					30	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	30	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	30	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	550		550		10	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	53,834	0	14,713	0	121,173	100.00
101.00	UNIT COST MULTIPLIER	28.680874	0.000000	7.838572	0.000000	1,211.730000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Descriptions		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)		MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00		11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DIETARY							8.00
9.00	NURSING ADMINISTRATION							9.00
10.00	ROUTINE MEDICAL SUPPLIES	9,369						10.00
11.00	MEDICAL RECORDS		9,369					11.00
12.00	STAFF TRANSPORTATION				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	100		13.00
14.00	PHARMACY				0	0	100	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	0	15.00
16.00	OTHER GENERAL SERVICE				0	100	100	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	9,192	9,192	0	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	105	105	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	72	72	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM				0	0	0	60.00
61.00	VOLUNTEER PROGRAM				0	0	0	61.00
62.00	FUNDRAISING				0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0	0	0	65.00
66.00	RESIDENTIAL CARE				0	0	0	66.00
67.00	ADVERTISING				0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING				0	0	0	68.00
69.00	THRIFT STORE				0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	0	71.00
99.00	NEGATIVE COST CENTER							99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6,178	12,072	0	5,409	334	100.00	
101.00	UNIT COST MULTIPLIER	0.659409	1.288505	0.000000	54.090000	3.340000	101.00	

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0065

Period:

Worksheet 0-6

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
3/31/2025 9:29 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	9,369				15.00
16.00	OTHER GENERAL SERVICE		9,369			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			177		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	9,192	9,192			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	105	105	105		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	72	72	72		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	35,620	32,414	12,139		100.00
101.00	UNIT COST MULTIPLIER	3.801900	3.459708	68.581921		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 15-0065

Period:

Worksheet 0-7

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024

Date/Time Prepared:
3/31/2025 9:29 am

			Hospice I				
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
			0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.422503	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.213050	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.282775	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.645418	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.243803	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.500223	0	0	0	7.00
8.00	BEHAVIORAL HEALTH	93.00	1.028952	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	WOUND CARE (DIABETES CENTER)	76.00	0.536598	0	0	0	10.00
10.01	OTHER ANCILLARY CMS LINE	76.01	0.000000	0	0	0	10.01
10.02	CASE MANAGEMENT	76.02	0.000000	0	0	0	10.02
10.03	PAIN MANAGEMENT	76.03	1.211014	0	0	0	10.03
10.04	SLEEP LAB	76.04	0.222387	0	0	0	10.04
10.05	ONCOLOGY	76.05	0.292836	0	0	0	10.05
10.97	CARDIAC REHABILITATION	76.97	2.027325	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service		Costs by LOC		
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	BEHAVIORAL HEALTH	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	WOUND CARE (DIABETES CENTER)	0	0	0	0	0	10.00
10.01	OTHER ANCILLARY CMS LINE	0	0	0	0	0	10.01
10.02	CASE MANAGEMENT	0	0	0	0	0	10.02
10.03	PAIN MANAGEMENT	0	0	0	0	0	10.03
10.04	SLEEP LAB	0	0	0	0	0	10.04
10.05	ONCOLOGY	0	0	0	0	0	10.05
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0065

Period:

Worksheet 0-8

Hospice CCN: 15-1529

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,271,557	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			9,192	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			138.33	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	8,753	62		9.00
10.00	Program cost (line 8 times line 9)	1,210,802	8,576		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			56,769	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			105	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			540.66	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	105	0		14.00
15.00	Program cost (line 13 times line 14)	56,769	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			50,352	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			72	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			699.33	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	68	1		19.00
20.00	Program cost (line 18 times line 19)	47,554	699		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,378,678	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			9,369	22.00
23.00	Average cost per diem (line 21 divided by line 22)			147.15	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet L Parts I-III Date/Time Prepared: 3/31/2025 9:29 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		334,280	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,462	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		20.54	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		360,742	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8565

From 01/01/2024

To 12/31/2024

Date/Time Prepared:
3/31/2025 9:29 am

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	64,438	0	64,438	0	64,438	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	127,839	0	127,839	0	127,839	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	57,946	0	57,946	0	57,946	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	54,234	0	54,234	0	54,234	9.00
10.00	Subtotal (sum of lines 1 through 9)	304,457	0	304,457	0	304,457	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	18,067	18,067	0	18,067	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	106,618	106,618	0	106,618	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124,685	124,685	0	124,685	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	304,457	124,685	429,142	0	429,142	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	0	0	0	0	0	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	1,991	1,991	0	1,991	29.00
30.00	Administrative Costs	36,438	2,735	39,173	0	39,173	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,438	4,726	41,164	0	41,164	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	340,895	129,411	470,306	0	470,306	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8565

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	64,438	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	127,839	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	57,946	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	54,234	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	304,457	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	18,067	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	106,618	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124,685	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	429,142	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,991	29.00
30.00	Administrative Costs	0	39,173	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	41,164	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	470,306	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8566

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	2,065,387	0	2,065,387	0	2,065,387
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	292,782	0	292,782	0	292,782
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	60,750	0	60,750	0	60,750
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	459,313	0	459,313	0	459,313
10.00	Subtotal (sum of lines 1 through 9)	2,878,232	0	2,878,232	0	2,878,232
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	125,246	125,246	0	125,246
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	116,860	116,860	0	116,860
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	242,106	242,106	0	242,106
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,878,232	242,106	3,120,338	0	3,120,338
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	32,150	32,150	0	32,150
30.00	Administrative Costs	100,595	15,784	116,379	-15,000	101,379
31.00	Total Facility Overhead (sum of lines 29 and 30)	100,595	47,934	148,529	-15,000	133,529
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,978,827	290,040	3,268,867	-15,000	3,253,867

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8566

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,065,387	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	292,782	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	60,750	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	459,313	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,878,232	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	125,246	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	116,860	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	242,106	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,120,338	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	32,150	29.00
30.00	Administrative Costs	0	101,379	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	133,529	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,253,867	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8568

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	269,808	269,808	1.00
2.00	Physician Assistant	0	0	0	76,404	76,404	2.00
3.00	Nurse Practitioner	0	0	0	154,566	154,566	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	81,066	81,066	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	47,178	47,178	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	629,022	629,022	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	183,825	183,825	0	183,825	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	3,298	3,298	0	3,298	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	187,123	187,123	0	187,123	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	187,123	187,123	629,022	816,145	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	4,251	4,251	0	4,251	29.00
30.00	Administrative Costs	896,542	19,297	915,839	-629,022	286,817	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	896,542	23,548	920,090	-629,022	291,068	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	896,542	210,671	1,107,213	0	1,107,213	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8568

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	269,808	1.00
2.00	Physician Assistant	0	76,404	2.00
3.00	Nurse Practitioner	0	154,566	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	81,066	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	47,178	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	629,022	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	183,825	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	3,298	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	187,123	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	816,145	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	4,251	29.00
30.00	Administrative Costs	0	286,817	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	291,068	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,107,213	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8569

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

				RHC V		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	1,960,873	1,960,873	1.00
2.00	Physician Assistant	0	0	0	190,251	190,251	2.00
3.00	Nurse Practitioner	0	0	0	560,188	560,188	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	953,596	953,596	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	3,664,908	3,664,908	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	154,265	154,265	0	154,265	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	265,549	265,549	0	265,549	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	419,814	419,814	0	419,814	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	419,814	419,814	3,664,908	4,084,722	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	0	0	0	0	29.00
30.00	Administrative Costs	3,983,913	23,308	4,007,221	-3,684,908	322,313	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,983,913	23,308	4,007,221	-3,684,908	322,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,983,913	443,122	4,427,035	-20,000	4,407,035	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8569

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

RHC V

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,960,873	1.00
2.00	Physician Assistant	0	190,251	2.00
3.00	Nurse Practitioner	0	560,188	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	953,596	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,664,908	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	154,265	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	265,549	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	419,814	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,084,722	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	0	29.00
30.00	Administrative Costs	0	322,313	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	322,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,407,035	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8575

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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				RHC VI		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	95,318	95,318	1.00
2.00	Physician Assistant	0	0	0	280,619	280,619	2.00
3.00	Nurse Practitioner	0	0	0	17,338	17,338	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	267,495	267,495	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	660,770	660,770	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	103,484	103,484	0	103,484	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	23,741	23,741	0	23,741	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	127,225	127,225	0	127,225	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	127,225	127,225	660,770	787,995	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	27,389	27,389	0	27,389	29.00
30.00	Administrative Costs	371,338	459,082	830,420	-726,110	104,310	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	371,338	486,471	857,809	-726,110	131,699	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	371,338	613,696	985,034	-65,340	919,694	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8575

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

3/31/2025 9:29 am

				RHC VI	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	95,318	1.00	
2.00	Physician Assistant	0	280,619	2.00	
3.00	Nurse Practitioner	0	17,338	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	0	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
7.10	Marriage and Family Therapist	0	0	7.10	
7.11	Mental Health Counselor	0	0	7.11	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	267,495	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	660,770	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00	
15.00	Medical Supplies	0	103,484	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	23,741	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	127,225	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	787,995	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	27,389	29.00	
30.00	Administrative Costs	-130	104,180	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-130	131,569	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-130	919,564	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8574

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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				RHC VII		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	104,873	104,873	1.00
2.00	Physician Assistant	0	0	0	4,151	4,151	2.00
3.00	Nurse Practitioner	0	0	0	413,522	413,522	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	190,930	190,930	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	713,476	713,476	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	189,326	189,326	0	189,326	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	27,416	27,416	0	27,416	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216,742	216,742	0	216,742	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	216,742	216,742	713,476	930,218	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	0	0	0	0	0	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	23,012	23,012	0	23,012	29.00
30.00	Administrative Costs	499,333	417,958	917,291	-713,476	203,815	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	499,333	440,970	940,303	-713,476	226,827	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	499,333	657,712	1,157,045	0	1,157,045	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8574

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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				RHC VII	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	104,873		1.00
2.00	Physician Assistant	0	4,151		2.00
3.00	Nurse Practitioner	0	413,522		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	190,930		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	713,476		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	189,326		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	27,416		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216,742		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	930,218		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	23,012		29.00
30.00	Administrative Costs	0	203,815		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	226,827		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,157,045		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8578

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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		RHC VIII		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	1,240	1,240
3.00	Nurse Practitioner	0	0	0	389,674	389,674
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	160,599	160,599
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	551,513	551,513
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	35,086	35,086	0	35,086
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	5,838	5,838	0	5,838
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	40,924	40,924	0	40,924
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	40,924	40,924	551,513	592,437
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,510	23,510	0	23,510
30.00	Administrative Costs	261,308	490,384	751,692	-650,100	101,592
31.00	Total Facility Overhead (sum of lines 29 and 30)	261,308	513,894	775,202	-650,100	125,102
32.00	Total facility costs (sum of lines 22, 28 and 31)	261,308	554,818	816,126	-98,587	717,539

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8578

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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		RHC VIII		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	1,240	2.00
3.00	Nurse Practitioner	0	389,674	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	160,599	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	551,513	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	35,086	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	5,838	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,924	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	592,437	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	23,510	29.00
30.00	Administrative Costs	0	101,592	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	125,102	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	717,539	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8586

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

						RHC IX	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
FACILITY HEALTH CARE STAFF COSTS								
1.00	Physician	0	0	0	1,401,907	1,401,907		1.00
2.00	Physician Assistant	0	0	0	68,381	68,381		2.00
3.00	Nurse Practitioner	0	0	0	653,245	653,245		3.00
4.00	Visiting Nurse	0	0	0	0	0		4.00
5.00	Other Nurse	0	0	0	123,312	123,312		5.00
6.00	Clinical Psychologist	0	0	0	0	0		6.00
7.00	Clinical Social Worker	0	0	0	0	0		7.00
7.10	Marriage and Family Therapist	0	0	0	0	0		7.10
7.11	Mental Health Counselor	0	0	0	0	0		7.11
8.00	Laboratory Technician	0	0	0	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	585,300	585,300		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	2,832,145	2,832,145		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	397,186	397,186	0	397,186		15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0		17.00
18.00	Professional Liability Insurance	0	0	0	0	0		18.00
19.00	Other Health Care Costs	0	19,372	19,372	0	19,372		19.00
20.00	Allowable GME Costs	0	0	0	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	416,558	416,558	0	416,558		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	416,558	416,558	2,832,145	3,248,703		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	0	0	0	0	0		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	20,791	20,791	0	20,791		29.00
30.00	Administrative Costs	3,178,372	45,164	3,223,536	-2,832,146	391,390		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,178,372	65,955	3,244,327	-2,832,146	412,181		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,178,372	482,513	3,660,885	-1	3,660,884		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0065

Period:

Worksheet M-1

Component CCN: 15-8586

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC IX		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,401,907	1.00
2.00	Physician Assistant	0	68,381	2.00
3.00	Nurse Practitioner	0	653,245	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	123,312	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	585,300	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,832,145	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	397,186	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	19,372	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	416,558	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,248,703	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	20,791	29.00
30.00	Administrative Costs	-285,996	105,394	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-285,996	126,185	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-285,996	3,374,888	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8565

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.09	772	4,200	378
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.92	2,867	2,100	1,932
4.00	Subtotal (sum of lines 1 through 3)	1.01	3,639	2,310	3,639
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
7.03	Marriage and Family Therapist	0.00	0		0
7.04	Mental Health Counselor	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.01	3,639		3,639
9.00	Physician Services Under Agreements		0		0
					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)				429,142
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				429,142
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				41,164
15.00	Parent provider overhead allocated to facility (see instructions)				426,204
16.00	Total overhead (sum of lines 14 and 15)				467,368
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				467,368
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				467,368
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				896,510

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES				Provider CCN: 15-0065 Component CCN: 15-8566		Period: From 01/01/2024 To 12/31/2024		Worksheet M-2 Date/Time Prepared: 3/31/2025 9:29 am	
				RHC III		Cost			
				Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
				1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY									
Positions									
1.00	Physician	3.43	3,866	4,200	14,406		1.00		
2.00	Physician Assistant	0.00	0	2,100	0		2.00		
3.00	Nurse Practitioner	0.89	964	2,100	1,869		3.00		
4.00	Subtotal (sum of lines 1 through 3)	4.32	4,830		16,275	16,275	4.00		
5.00	Visiting Nurse	0.00	0		0		5.00		
6.00	Clinical Psychologist	0.00	0		0		6.00		
7.00	Clinical Social Worker	0.00	0		0		7.00		
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0		7.01		
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0		7.02		
7.03	Marriage and Family Therapist	0.00	0		0		7.03		
7.04	Mental Health Counselor	0.00	0		0		7.04		
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.32	4,830			16,275	8.00		
9.00	Physician Services Under Agreements		0			0	9.00		
								1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES									
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)							3,120,338	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)							0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)							3,120,338	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)							133,529	14.00
15.00	Parent provider overhead allocated to facility (see instructions)							1,739,389	15.00
16.00	Total overhead (sum of lines 14 and 15)							1,872,918	16.00
17.00	Allowable GME overhead (see instructions)							0	17.00
18.00	Enter the amount from line 16							1,872,918	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)							1,872,918	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)							4,993,256	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8568

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

		RHC IV		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.88	2,345	4,200	3,696	1.00
2.00	Physician Assistant	0.50	1,552	2,100	1,050	2.00
3.00	Nurse Practitioner	1.07	3,903	2,100	2,247	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.45	7,800		6,993	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.45	7,800		7,800	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)				816,145	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)				816,145	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)				291,068	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				866,580	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,157,648	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,157,648	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,157,648	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,973,793	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8569

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

				RHC V		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	5.71	17,144	4,200	23,982		1.00
2.00	Physician Assistant	1.39	2,855	2,100	2,919		2.00
3.00	Nurse Practitioner	3.80	9,913	2,100	7,980		3.00
4.00	Subtotal (sum of lines 1 through 3)	10.90	29,912		34,881	34,881	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist	0.00	0			0	7.03
7.04	Mental Health Counselor	0.00	0			0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	10.90	29,912			34,881	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)					4,084,722	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)					4,084,722	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)					322,313	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,831,657	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,153,970	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,153,970	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,153,970	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,238,692	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8575

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

		RHC VI		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.37	1,215	4,200	1,554	1.00
2.00	Physician Assistant	1.09	3,577	2,100	2,289	2.00
3.00	Nurse Practitioner	0.07	221	2,100	147	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.53	5,013	3,990	5,013	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.53	5,013		5,013	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)				787,995	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)				787,995	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)				131,569	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				861,086	15.00
16.00	Total overhead (sum of lines 14 and 15)				992,655	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				992,655	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				992,655	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,780,650	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8574

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

					3/31/2025 9:29 am			
			RHC VII		Cost			
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.37	2,719	4,200	1,554			1.00
2.00	Physician Assistant	0.02	62	2,100	42			2.00
3.00	Nurse Practitioner	1.73	6,176	2,100	3,633			3.00
4.00	Subtotal (sum of lines 1 through 3)	2.12	8,957		5,229		8,957	4.00
5.00	Visiting Nurse	0.00	0				0	5.00
6.00	Clinical Psychologist	0.00	0				0	6.00
7.00	Clinical Social Worker	0.00	0				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0				0	7.02
7.03	Marriage and Family Therapist	0.00	0				0	7.03
7.04	Mental Health Counselor	0.00	0				0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.12	8,957				8,957	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)						930,218	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)						930,218	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)						226,827	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						976,210	15.00
16.00	Total overhead (sum of lines 14 and 15)						1,203,037	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						1,203,037	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						1,203,037	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						2,133,255	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8578

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

				RHC VIII		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.01	14	2,100	21		2.00
3.00	Nurse Practitioner	1.39	4,400	2,100	2,919		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.40	4,414		2,940	4,414	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist	0.00	0			0	7.03
7.04	Mental Health Counselor	0.00	0			0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.40	4,414			4,414	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)					592,437	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)					592,437	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)					125,102	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					598,621	15.00
16.00	Total overhead (sum of lines 14 and 15)					723,723	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					723,723	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					723,723	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,316,160	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0065

Period:

Worksheet M-2

Component CCN: 15-8586

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		RHC IX		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	3.71	5,430	4,200	15,582
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	4.45	10,046	2,100	9,345
4.00	Subtotal (sum of lines 1 through 3)	8.16	15,476		24,927
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
7.03	Marriage and Family Therapist	0.00	0		0
7.04	Mental Health Counselor	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.16	15,476		24,927
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				3,248,703
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,248,703
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				126,185
15.00	Parent provider overhead allocated to facility (see instructions)				2,015,219
16.00	Total overhead (sum of lines 14 and 15)				2,141,404
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				2,141,404
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,141,404
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,390,107

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8564	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			0	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			0	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			0	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)			0	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			0.00	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	0.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)			0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			0	16.04
16.05	Total program cost (see instructions)		0	0	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			0	22.00
23.00	Allowable bad debts (see instructions)			373	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			242	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-40	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)			242	26.00
26.01	Sequestration adjustment (see instructions)			5	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			0	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)			237	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8565	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			896,510	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			273,867	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			622,643	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,639	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)			3,639	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			171.10	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	695	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	96,605	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	96,605	16.00
16.01	Total program charges (see instructions)(from contractor's records)			116,517	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			10,977	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			9,101	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.)			56,070	16.04
16.05	Total program cost (see instructions)		0	65,171	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,417	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			17,604	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			65,171	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,452	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			92,623	22.00
23.00	Allowable bad debts (see instructions)			1,793	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			1,165	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			368	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)			93,788	26.00
26.01	Sequestration adjustment (see instructions)			1,876	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			60,860	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)			31,052	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8566	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
			Title XVIII	RHC III	Cost
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,993,256	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			20,548	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,972,708	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,275	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)			16,275	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			305.54	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	247	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	34,333	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	34,333	16.00
16.01	Total program charges (see instructions)(from contractor's records)			19,449	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,974	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			5,250	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.)			21,998	16.04
16.05	Total program cost (see instructions)		0	27,248	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,585	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			2,978	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			27,248	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			27,248	22.00
23.00	Allowable bad debts (see instructions)			69	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			45	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			46	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)			27,293	26.00
26.01	Sequestration adjustment (see instructions)			546	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			26,656	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)			91	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3	
		Component CCN: 15-8568		Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	RHC IV	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,973,793	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			404,908	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,568,885	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,800	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)			7,800	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			201.14	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	557	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	77,423	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	77,423	16.00
16.01	Total program charges (see instructions)(from contractor's records)			62,254	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			53,963	16.04
16.05	Total program cost (see instructions)		0	53,963	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			9,969	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			10,457	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			53,963	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			36,750	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			90,713	22.00
23.00	Allowable bad debts (see instructions)			353	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			229	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			56	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)			90,942	26.00
26.01	Sequestration adjustment (see instructions)			1,819	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			42,112	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)			47,011	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065	Period: From 01/01/2024	Worksheet M-3	
		Component CCN: 15-8569	To 12/31/2024	Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	RHC V	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,238,692	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			734,902	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,503,790	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			34,881	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)			34,881	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			215.13	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,776	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	663,864	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	663,864	16.00
16.01	Total program charges (see instructions)(from contractor's records)			670,323	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			60,296	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			59,715	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.)			405,693	16.04
16.05	Total program cost (see instructions)		0	465,408	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			97,033	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			102,599	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			465,408	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			82,149	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			547,557	22.00
23.00	Allowable bad debts (see instructions)			5,515	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			3,585	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,356	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)			551,142	26.00
26.01	Sequestration adjustment (see instructions)			11,023	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			453,674	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)			86,445	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8575	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
			Title XVIII	RHC VI	Cost
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,780,650	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			217,973	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,562,677	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,013	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,013	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			311.72	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	417	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	57,963	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	57,963	16.00
16.01	Total program charges (see instructions)(from contractor's records)			42,469	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			42,672	16.04
16.05	Total program cost (see instructions)		0	42,672	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,623	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			7,569	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			42,672	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			30,498	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			73,170	22.00
23.00	Allowable bad debts (see instructions)			480	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			312	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			160	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)			73,482	26.00
26.01	Sequestration adjustment (see instructions)			1,470	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			38,192	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)			33,820	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8574	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
		Title XVIII	RHC VII	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,133,255	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			362,998	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,770,257	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,957	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,957	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			197.64	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	722	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	100,358	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	100,358	16.00
16.01	Total program charges (see instructions)(from contractor's records)			82,265	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			75,099	16.04
16.05	Total program cost (see instructions)		0	75,099	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,484	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			15,156	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			75,099	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			48,986	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			124,085	22.00
23.00	Allowable bad debts (see instructions)			292	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			190	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			218	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			124,275	26.00
26.01	Sequestration adjustment (see instructions)			2,486	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			53,443	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)			68,346	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8578	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
			Title XVIII	RHC VIII	Cost
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,316,160	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			63,189	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,252,971	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,414	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)			4,414	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			283.86	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	452	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	62,828	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	62,828	16.00
16.01	Total program charges (see instructions)(from contractor's records)			47,199	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			47,278	16.04
16.05	Total program cost (see instructions)		0	47,278	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			3,731	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			8,694	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			47,278	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			18,339	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			65,617	22.00
23.00	Allowable bad debts (see instructions)			131	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			85	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			131	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)			65,702	26.00
26.01	Sequestration adjustment (see instructions)			1,314	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			46,308	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)			18,080	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0065 Component CCN: 15-8586	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 3/31/2025 9:29 am	
			Title XVIII	RHC IX	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)			5,390,107	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			887,831	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,502,276	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,927	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)			24,927	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			180.62	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)			0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			0	16.04
16.05	Total program cost (see instructions)		0	0	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			51,197	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			51,197	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)			51,197	26.00
26.01	Sequestration adjustment (see instructions)			1,024	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			0	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)			50,173	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: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8565

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	304,457	304,457	304,457	304,457	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.021101	0.024116	0.090512	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,424	7,342	27,557	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	65,417	9,889	14,466	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	71,841	17,231	42,023	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	429,142	429,142	429,142	429,142	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	467,368	467,368	467,368	467,368	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.167406	0.040152	0.097923	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	78,240	18,766	45,766	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	150,081	35,997	87,789	0	10.00
11.00	Total number of injections/infusions (from your records)	266	304	163	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	564.21	118.41	538.58	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	59	38	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	6,986	20,466	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)				273,867	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)				27,452	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

From 01/01/2024

To 12/31/2024

Worksheet M-4

Date/Time Prepared:

3/31/2025 9:29 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,878,232	2,878,232	2,878,232	2,878,232	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.002281	0.000297	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	6,565	855	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	4,001	1,420	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	10,566	2,275	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,120,338	3,120,338	3,120,338	3,120,338	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,872,918	1,872,918	1,872,918	1,872,918	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003386	0.000729	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	6,342	1,365	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	16,908	3,640	0	10.00
11.00	Total number of injections/infusions (from your records)	0	123	16	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	137.46	227.50	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				20,548	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8568

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	629,022	629,022	629,022	629,022	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000033	0.050072	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	21	31,496	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	33	135,876	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	54	167,372	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	816,145	816,145	816,145	816,145	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,157,648	1,157,648	1,157,648	1,157,648	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000066	0.205076	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	76	237,406	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	130	404,778	0	10.00
11.00	Total number of injections/infusions (from your records)	0	1	1,531	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	130.00	264.39	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	139	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	36,750	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)				404,908	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)				36,750	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8569

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC V	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,664,908	3,664,908	3,664,908	3,664,908	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003257	0.009961	0.010351	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	11,937	36,506	37,935	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	108,947	44,078	124,960	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	120,884	80,584	162,895	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,084,722	4,084,722	4,084,722	4,084,722	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,153,970	4,153,970	4,153,970	4,153,970	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.029594	0.019728	0.039879	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	122,933	81,950	165,656	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	243,817	162,534	328,551	0	10.00
11.00	Total number of injections/infusions (from your records)	443	1,355	1,408	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	550.38	119.95	233.35	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	288	204	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	34,546	47,603	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)				734,902	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)				82,149	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8575

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC VI	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	660,770	660,770	660,770	660,770	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000471	0.007071	0.036036	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	311	4,672	23,812	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,213	4,392	61,060	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,524	9,064	84,872	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	787,995	787,995	787,995	787,995	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	992,655	992,655	992,655	992,655	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003203	0.011503	0.107706	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,179	11,419	106,915	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,703	20,483	191,787	0	10.00
11.00	Total number of injections/infusions (from your records)	9	135	688	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	633.67	151.73	278.76	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	42	82	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,267	6,373	22,858	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)				217,973	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)				30,498	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8574

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

3/31/2025 9:29 am

		Title XVIII		RHC VII	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)	713,476	713,476	713,476	713,476	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002646	0.008881	0.040892	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,888	6,336	29,175	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,215	7,645	96,028	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,103	13,981	125,203	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	930,218	930,218	930,218	930,218	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,203,037	1,203,037	1,203,037	1,203,037	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.020536	0.015030	0.134595	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	24,706	18,082	161,923	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	43,809	32,063	287,126	0	10.00
11.00	Total number of injections/infusions (from your records)	70	235	1,082	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	625.84	136.44	265.37	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	17	71	108	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)	10,639	9,687	28,660	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)				362,998	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)				48,986	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8578

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC VIII	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)	551,513	551,513	551,513	551,513	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001431	0.005666	0.007212	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	789	3,125	3,978	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,148	3,220	11,183	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,937	6,345	15,161	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	592,437	592,437	592,437	592,437	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	723,723	723,723	723,723	723,723	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011709	0.010710	0.025591	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,474	7,751	18,521	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15,411	14,096	33,682	0	10.00
11.00	Total number of injections/infusions (from your records)	25	99	126	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	616.44	142.38	267.32	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	38	23	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,781	5,410	6,148	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)				63,189	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)				18,339	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0065

Period:

Worksheet M-4

Component CCN: 15-8586

From 01/01/2024
To 12/31/2024Date/Time Prepared:
3/31/2025 9:29 am

		Title XVIII		RHC IX	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,832,145	2,832,145	2,832,145	2,832,145	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.013266	0.008897	0.009319	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	37,571	25,198	26,393	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	332,251	29,472	84,224	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	369,822	54,670	110,617	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,248,703	3,248,703	3,248,703	3,248,703	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,141,404	2,141,404	2,141,404	2,141,404	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.113837	0.016828	0.034050	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	243,771	36,036	72,915	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	613,593	90,706	183,532	0	10.00
11.00	Total number of injections/infusions (from your records)	1,351	906	949	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	454.18	100.12	193.40	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	136	145	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9,538	13,616	28,043	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)				887,831	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)				51,197	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8565	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			60,860	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)			60,860	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			31,052	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			91,912	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8566	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC III	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		26,656	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		26,656		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		91		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		26,747		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8568	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			42,112	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)			42,112	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			47,011	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			89,123	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8569	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC V	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		453,674	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)		453,674	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		86,445	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		540,119	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8575	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC VI	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		38,192	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)		38,192		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		33,820		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		72,012		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8574	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC VII	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		53,443	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)		53,443		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		68,346		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		121,789		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0065 Component CCN: 15-8578	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 3/31/2025 9:29 am	
		RHC VIII		Cost	
		Part B			
		mm/dd/yyyy		Amount	
		1.00		2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			46,308	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)			46,308	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			18,080	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			64,388	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Health Financial Systems		SCHNECK MEDICAL CENTER		In Lieu of Form CMS-2552-10	
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: 15-0065		Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 3/31/2025 9:29 am
PART I - COST REPORT STATUS					
Provider use only		Date: 3/31/2025 Time: 9:29 am			
1. ☒ Electronically prepared cost report					
2. ☐ Manually prepared cost report					
3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report					
4. ☐ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.					
Contractor use only					
5. ☐ Cost Report Status		6. Date Received:		10. NPR Date:	
(1) As Submitted		7. Contractor No.		11. Contractor's Vendor Code: 4	
(2) Settled without Audit		8. ☐ Initial Report for this Provider CCN		12. ☐ If line 5, column 1 is 4: Enter	
(3) Settled with Audit		9. ☐ Final Report for this Provider CCN		number of times reopened = 0-9.	
(4) Reopened					
(5) Amended					
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 SCHNECK MEDICAL CENTER (15-0065) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 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		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		Debbie Mann			2
3 Signatory Title		CHIEF FINANCIAL OFFICER			3
4 Date		03/31/2025 06:44:21 AM (PT)			4
Encryption Information					
ECR: Date: 3/31/2025 Time: 9:29 am					
drrXiuWmMD3G2SjrHZc6.Cv3DytSG0					
VwG.u078HwVgUFxzRb2Ve9bnaia.K6					
Yud92Ghv060NG0Y.					
		Title V	Title XVIII		
			Part A	Part B	
		1.00	2.00	3.00	
					HIT
					Title XIX
					5.00
PART III - SETTLEMENT SUMMARY					
1.00	HOSPITAL	0	227,348	20,140	0
2.00	SUBPROVIDER - IPF	0	0	0	0
3.00	SUBPROVIDER - IRF	0	0	0	0
5.00	SWING BED - SNF	0	0	0	0
6.00	SWING BED - NF	0			0
9.00	HOME HEALTH AGENCY I	0	0	0	0
10.00	RHC I JACKSON	0		237	0
10.01	RHC II BROWSTOWN	0		31,052	0
10.02	RHC III OBGYN	0		91	0
10.03	RHC IV URGENT CARE	0		47,011	0
10.04	RHC V SPC IM PEDS	0		86,445	0
10.05	RHC VI JENNINGS	0		33,820	0
10.06	RHC VII SCOTT	0		68,346	0
10.07	RHC VIII WASHINGTON CO	0		18,080	0
10.08	RHC IX PEDS & ADULT MEDICINE	0		50,173	0
200.00	TOTAL	0	227,348	355,395	0
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.					