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: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet S Parts I-III Date/Time Prepared: 2/24/2025 12:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/24/2025 Time: 12:45 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2023 and ending 09/30/2024 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	Andrew Kleber		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	Andrew Kleber			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	32,242	501,038	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-48,657	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		64,388		0	10.00
10.01	RURAL HEALTH CLINIC II	0		7,216		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-1,423		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		65,396		0	10.03
10.04	RURAL HEALTH CLINIC V	0		39,989		0	10.04
200.00	TOTAL	0	-16,415	676,604	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CAMERON URGENT CARE	158545	99915		11/26/2019	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMERON OB/GYN	158546	99915		11/25/2019	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CAMERON NORTH	158570	99915		12/14/2022	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	CAMERON FREMONT	158571	99915		07/18/2023	N	O	O	15.04
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2023	09/30/2024	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic 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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

		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 | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

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

	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00
		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
				1.00	
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	232,017	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	N	123.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

		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)	Y		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	06/26/2023	146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 2/24/2025 12:45 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2025 12:45 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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	12/20/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, 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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	11/11/2024	Y	11/11/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2025 12:45 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608.270.2962	DGOODMAN@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part II Date/Time Prepared: 2/24/2025 12:45 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2025 12:45 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,418	47,800.81	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,418	47,800.81	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	732	1,743.19	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)		25	9,150	49,544.00	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	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	527	81	2,289			1.00
2.00	HMO and other (see instructions)	496	0				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	427	0	1,253			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	53			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	954	81	3,595			7.00
8.00	INTENSIVE CARE UNIT	21	2	89			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		46	470			13.00
14.00	Total (see instructions)	975	129	4,154	0.00	450.91	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,085	0	8,878	0.00	10.22	26.00
26.01	RURAL HEALTH CLINIC II	1,156	0	20,479	0.00	16.07	26.01
26.02	RURAL HEALTH CLINIC III	113	0	7,110	0.00	10.26	26.02
26.03	RURAL HEALTH CLINIC IV	1,160	0	8,818	0.00	9.41	26.03
26.04	RURAL HEALTH CLINIC V	966	0	6,653	0.00	8.56	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	18.37	26.25
27.00	Total (sum of lines 14-26)				0.00	523.80	27.00
28.00	Observation Bed Days		0	2,028			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	86			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 | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	204	34	971	1.00
2.00	HMO and other (see instructions)			155	0		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	204	34	971	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	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	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	16:30	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			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		STEUBEN				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8530

Period:
From 10/01/2023
To 09/30/2024

Worksheet S-8
Date/Time Prepared:
2/24/2025 12:45 pm

RHC I | 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	16:30	08:00	16:30	16:30	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	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1381 N. WAYNE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	09:00	17:30	08:00	19:30	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			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						2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8545

Period:
From 10/01/2023
To 09/30/2024

Worksheet S-8
Date/Time Prepared:
2/24/2025 12:45 pm

RHC II | 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	19:30	08:00	19:30	08:00	19:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:30	09:00	17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			306 E. MAUMEE STREET SUITE 101		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	16:30	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			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						2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

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	16:30	08:00	16:30	08:00	16:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3250 INTERTECH DRIVE, STE A		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	16:30	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		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	STEUBEN		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

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	16:30	08:00	16:30	08:00	16:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-8 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			401 SOUTH BROAD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FREMONT		IN	46737	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	20:00	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			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		STEUBEN				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8571

Period:
From 10/01/2023
To 09/30/2024

Worksheet S-8
Date/Time Prepared:
2/24/2025 12:45 pm

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	16:30	08:00	16:30	08:00	16:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/24/2025 12:45 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.327257	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,636,045	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	39,285,928	6.00
7.00	Medicaid cost (line 1 times line 6)	12,856,595	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,220,550	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)	1,220,550	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)	329,581	0	329,581	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	107,858	0	107,858	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)	107,858	0	107,858	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	5,990,026	26.00
27.00	Medicare reimbursable bad debts (see instructions)	422,881	27.00
27.01	Medicare allowable bad debts (see instructions)	650,587	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,339,439	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,975,075	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,082,933	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,303,483	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/24/2025 12:45 pm

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,625,781	4,625,781	157,890	4,783,671	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,018,694	2,018,694	1,205,702	3,224,396	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	485,281	14,133,734	14,619,015	-1,342,016	13,276,999	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,177,045	9,500,852	17,677,897	-45,863	17,632,034	5.00
7.00	00700	OPERATION OF PLANT	1,515,920	2,682,064	4,197,984	0	4,197,984	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	911	911	162,230	163,141	8.00
9.00	00900	HOUSEKEEPING	907,824	846,907	1,754,731	-162,230	1,592,501	9.00
10.00	01000	DIETARY	560,627	632,137	1,192,764	-59,638	1,133,126	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	476,877	36,039	512,916	0	512,916	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	351,227	188,277	539,504	0	539,504	14.00
15.00	01500	PHARMACY	462,704	11,291,995	11,754,699	-10,869,448	885,251	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917,311	428,947	1,346,258	0	1,346,258	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,162,411	1,447,968	5,610,379	-98,665	5,511,714	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	58,865	58,865	31.00
43.00	04300	NURSERY	0	0	0	17,252	17,252	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,012,232	1,652,406	3,664,638	-944,141	2,720,497	50.00
51.00	05100	RECOVERY ROOM	0	0	0	944,141	944,141	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,563	449	74,012	22,548	96,560	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,610,489	1,241,331	3,851,820	0	3,851,820	54.00
60.00	06000	LABORATORY	1,423,140	2,484,260	3,907,400	0	3,907,400	60.00
65.00	06500	RESPIRATORY THERAPY	1,143,117	266,092	1,409,209	-210,619	1,198,590	65.00
65.01	06501	SLEEP LAB	0	0	0	116,412	116,412	65.01
66.00	06600	PHYSICAL THERAPY	1,501,713	47,694	1,549,407	0	1,549,407	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,665	5,665	94,207	99,872	69.00
69.01	06901	CARDIAC REHABILITATION	82,414	9,250	91,664	0	91,664	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,834,641	2,834,641	-1,984,356	850,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,984,356	1,984,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,422,006	7,422,006	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	2,298,011	2,298,011	0	2,298,011	76.01
76.02	03030	DIABETIC EDUCATION	0	87,754	87,754	0	87,754	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,082,623	170,308	1,252,931	65,036	1,317,967	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,633,587	341,972	1,975,559	322,056	2,297,615	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,060,319	393,425	1,453,744	94,584	1,548,328	88.02
88.03	08803	RURAL HEALTH CLINIC IV	941,157	129,016	1,070,173	204,980	1,275,153	88.03
88.04	08804	RURAL HEALTH CLINIC V	922,300	119,532	1,041,832	59,171	1,101,003	88.04
90.00	09000	CLINIC	108,372	20,561	128,933	0	128,933	90.00
90.01	09001	CLINIC- ORTHO	926,669	1,192,482	2,119,151	150,223	2,269,374	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,080,293	281,717	2,362,010	344,758	2,706,768	90.02
90.03	09003	INTRAVENOUS THERAPY	91,756	18,483	110,239	3,270,740	3,380,979	90.03
90.04	09004	PSYCHIATRY	1,695,467	119,790	1,815,257	299,867	2,115,124	90.04
90.05	09005	CARDIOLOGY	843,762	229,130	1,072,892	23,028	1,095,920	90.05
91.00	09100	EMERGENCY	2,295,615	525,060	2,820,675	0	2,820,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,263,446	1,263,446	-1,263,446	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,545,815	63,566,781	104,112,596	39,630	104,152,226	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	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	64,529	58,441	122,970	-57,736	65,234	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	321,743	853,257	1,175,000	-128,384	1,046,616	194.05
194.06	07956	GUEST MEALS	0	0	0	59,638	59,638	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	120,014	7,833	127,847	0	127,847	194.12

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.13	07963	OCCUPATIONAL HEALTH	420,761	78,806	499,567	43,292	542,859	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	161,060	241,588	402,648	2,947	405,595	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	103,630	17,931	121,561	0	121,561	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	190,690	2,741	193,431	40,613	234,044	194.18
200.00		TOTAL (SUM OF LINES 118 through 199)	41,928,242	64,827,378	106,755,620	0	106,755,620	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,260,829	3,522,842		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-17,023	3,207,373		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-303,402	12,973,597		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,897,753	13,734,281		5.00
7.00	00700	OPERATION OF PLANT	0	4,197,984		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	163,141		8.00
9.00	00900	HOUSEKEEPING	0	1,592,501		9.00
10.00	01000	DIETARY	-344,045	789,081		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	512,916		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,300	536,204		14.00
15.00	01500	PHARMACY	-11,277	873,974		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-316	1,345,942		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-904,409	4,607,305		30.00
31.00	03100	INTENSIVE CARE UNIT	0	58,865		31.00
43.00	04300	NURSERY	0	17,252		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-641,174	2,079,323		50.00
51.00	05100	RECOVERY ROOM	0	944,141		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	96,560		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,875	3,843,945		54.00
60.00	06000	LABORATORY	-5,992	3,901,408		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,198,590		65.00
65.01	06501	SLEEP LAB	0	116,412		65.01
66.00	06600	PHYSICAL THERAPY	-2,100	1,547,307		66.00
69.00	06900	ELECTROCARDIOLOGY	0	99,872		69.00
69.01	06901	CARDIAC REHABILITATION	-1,482	90,182		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	850,285		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,984,356		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,474,182	1,947,824		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	-43,116	2,254,895		76.01
76.02	03030	DIABETIC EDUCATION	0	87,754		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,317,967		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,297,615		88.01
88.02	08802	RURAL HEALTH CLINIC III	-40,773	1,507,555		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-49,084	1,226,069		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,101,003		88.04
90.00	09000	CLINIC	0	128,933		90.00
90.01	09001	CLINIC- ORTHO	-1,733,798	535,576		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	-1,423,199	1,283,569		90.02
90.03	09003	INTRAVENOUS THERAPY	0	3,380,979		90.03
90.04	09004	PSYCHIATRY	-1,422,775	692,349		90.04
90.05	09005	CARDIOLOGY	-707,241	388,679		90.05
91.00	09100	EMERGENCY	0	2,820,675		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,295,145	85,857,081		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	65,234		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	0		194.04
194.05	07955	MARKETING	0	1,046,616		194.05
194.06	07956	GUEST MEALS	0	59,638		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	0		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	127,847		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	542,859		194.13

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.14	07964	IMMUNIZATION CLINIC	0	0		194.14
194.15	07965	FOUNDATION	0	405,595		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	121,561		194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	234,044		194.18
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,295,145	88,460,475		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-6 | Date/Time Prepared: 2/24/2025 12:45 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	14,096	3,156	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	18,424	4,124	2.00
	TOTALS		32,520	7,280	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	86,645	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,782	2.00
	TOTALS		0	100,427	
	C - CAFETERIA				
1.00	GUEST MEALS	194.06	28,031	31,607	1.00
	TOTALS		28,031	31,607	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,260,829	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,617	2.00
	TOTALS		0	1,263,446	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,189,303	1.00
	TOTALS		0	1,189,303	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	52,961	5,904	1.00
	TOTALS		52,961	5,904	
	G - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,923	1.00
	TOTALS		0	14,923	
	H - SLEEP LAB - EKG				
1.00	SLEEP LAB	65.01	68,710	47,702	1.00
2.00	ELECTROCARDIOLOGY	69.00	3,068	2,012	2.00
	TOTALS		71,778	49,714	
	I - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	6,784	1.00
	TOTALS		0	6,784	
	J - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	944,141	0	1.00
	TOTALS		944,141	0	
	K - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,984,356	1.00
	TOTALS		0	1,984,356	
	L - FOUNDATION RECLASS				
1.00	FOUNDATION	194.15	2,947	0	1.00
	TOTALS		2,947	0	
	M - IMMUNIZATION CLINIC RECLASS				
1.00	CLINIC - PEDS ENT FP GI	90.02	0	176,702	1.00
	TOTALS		0	176,702	
	N - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,692,746	1.00
	TOTALS		0	10,692,746	
	O - IV THERAPY				
1.00	INTRAVENOUS THERAPY	90.03	0	3,270,740	1.00
	TOTALS		0	3,270,740	
	P - EKG HST RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	89,127	0	1.00
	TOTALS		89,127	0	
	Q - OFFSITE DEPRECIATION				
1.00	RURAL HEALTH CLINIC IV	88.03	0	5,232	1.00
2.00	RURAL HEALTH CLINIC V	88.04	0	9,972	2.00
	TOTALS		0	15,204	
	R - PROVIDER BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	65,036	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	322,056	2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	94,584	3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	199,748	4.00
5.00	RURAL HEALTH CLINIC V	88.04	0	49,199	5.00
6.00	CLINIC- ORTHO	90.01	0	150,223	6.00
7.00	CLINIC - PEDS ENT FP GI	90.02	0	152,106	7.00
8.00	PSYCHIATRY	90.04	0	259,867	8.00
9.00	CARDIOLOGY	90.05	0	23,028	9.00
10.00	OCCUPATIONAL HEALTH	194.13	0	43,292	10.00
11.00	OBGYN CLINIC - FORT WAYNE	194.18	0	40,613	11.00
	TOTALS		0	1,399,752	
	T - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	162,230	1.00
	TOTALS		0	162,230	

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-6 | Date/Time Prepared: 2/24/2025 12:45 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	V - ALLOWABLE MARKETING COST RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	19,975	59,243		1.00
2.00	CLINIC - PEDS ENT FP GI	90.02	0	15,950		2.00
3.00	PSYCHIATRY	90.04	0	40,000		3.00
	TOTALS		19,975	115,193		
	W - EMPLOYEE WELLNESS COST RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28,515	29,221		1.00
	TOTALS		28,515	29,221		
500.00	Grand Total: Increases		1,269,995	20,515,532		500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-6 | Date/Time Prepared: 2/24/2025 12:45 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	32,520	7,280	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		32,520	7,280			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	100,427	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	100,427			
	C - CAFETERIA						
1.00	DIETARY	10.00	28,031	31,607	0		1.00
	TOTALS		28,031	31,607			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,263,446	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,263,446			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,189,303	9		1.00
	TOTALS		0	1,189,303			
	F - ICU						
1.00	ADULTS & PEDIATRICS	30.00	52,961	5,904	0		1.00
	TOTALS		52,961	5,904			
	G - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,923	9		1.00
	TOTALS		0	14,923			
	H - SLEEP LAB - EKG						
1.00	RESPIRATORY THERAPY	65.00	71,778	49,714	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		71,778	49,714			
	I - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,784	0		1.00
	TOTALS		0	6,784			
	J - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	944,141	0	0		1.00
	TOTALS		944,141	0			
	K - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,984,356	0		1.00
	TOTALS		0	1,984,356			
	L - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,947	0	0		1.00
	TOTALS		2,947	0			
	M - IMMUNIZATION CLINIC RECLASS						
1.00	PHARMACY	15.00	0	176,702	0		1.00
	TOTALS		0	176,702			
	N - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	10,692,746	0		1.00
	TOTALS		0	10,692,746			
	O - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,270,740	0		1.00
	TOTALS		0	3,270,740			
	P - EKG HST RECLASS						
1.00	RESPIRATORY THERAPY	65.00	89,127	0	0		1.00
	TOTALS		89,127	0			
	Q - OFFSITE DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,204	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	15,204			
	R - PROVIDER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,399,752	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
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	1,399,752			
	T - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	162,230	0		1.00
	TOTALS		0	162,230			

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-6 | Date/Time Prepared: 2/24/2025 12:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	V - ALLOWABLE MARKETING COST RECLASS						
1.00	MARKETING	194.05	19,975	59,243	0		1.00
2.00	MARKETING	194.05	0	15,950	0		2.00
3.00	MARKETING	194.05	0	40,000	0		3.00
	TOTALS		19,975	115,193			
	W - EMPLOYEE WELLNESS COST RECLASS						
1.00	COMMUNITY HEALTH	194.02	28,515	29,221	0		1.00
	TOTALS		28,515	29,221			
500.00	Grand Total: Decreases		1,269,995	20,515,532			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,019,703	220,469	0	220,469	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	61,381,452	360,829	0	360,829	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,206,348	2,913,615	0	2,913,615	1,537,200	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	84,607,503	3,494,913	0	3,494,913	1,537,200	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	84,607,503	3,494,913	0	3,494,913	1,537,200	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,240,172	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	61,742,281	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	22,582,763	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	86,565,216	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	86,565,216	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-7 Part II | Date/Time Prepared: 2/24/2025 12:45 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,625,781	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,018,694	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,625,781	2,018,694	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	4,625,781	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,018,694	2.00
3.00	Total (sum of lines 1-2)	0	6,644,475	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2025 12:45 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,742,281	0	61,742,281	0.732194	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,582,763	0	22,582,763	0.267806	0	2.00
3.00	Total (sum of lines 1-2)	84,325,044	0	84,325,044	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	3,436,197	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,174,897	2,018,694	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,611,094	2,018,694	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	86,645	0	0	3,522,842	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,782	0	0	3,207,373	2.00
3.00	Total (sum of lines 1-2)	0	100,427	0	0	6,730,215	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-8 | Date/Time Prepared: 2/24/2025 12:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-1,260,829	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-2,617	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-12,980	ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,828,732			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	-351,408			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-322,921	DIETARY	10.00	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	-11,277	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-316	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	B	-3,909	DIETARY	10.00	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	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-8 | Date/Time Prepared: 2/24/2025 12:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-6,708	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MEALS ON WHEELS	B	-17,215	DIETARY	10.00	0	33.01
33.02	RENTAL INCOME OFFSET - CANCER CENTER	B	-43,116	ONCOLOGY	76.01	0	33.02
33.03	ATM SURCHARGE REVENUE	B	-181	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RHC OB PHYSICIAN & MIDLEVELS OFFSET	A	-40,773	RURAL HEALTH CLINIC III	88.02	0	33.04
33.05	MEDICAID HAF EXPENSE	A	-3,760,790	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PHYSICIAN RECRUITMENT	A	-30	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC REVENUE	B	-83,645	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER PHYSICIAL THERAPY REVENUE	B	-2,100	PHYSICAL THERAPY	66.00	0	33.08
33.09	CARDIAC REHAB FITNESS REVENUE	B	-1,482	CARDIAC REHABILITATION	69.01	0	33.09
33.10	ALCOHOL EXPENSE	A	-3,119	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NORTH RHC RENTAL REVENUE	B	-49,084	RURAL HEALTH CLINIC IV	88.03	0	33.11
33.12	GI PROVIDER RECRUITMENT FEES	A	-991	CLINIC - PEDS ENT FP GI	90.02	0	33.12
33.13	PSYCH PROVIDER RECRUITMENT FEES	A	-1,740	PSYCHIATRY	90.04	0	33.13
33.14	CARDIOLOGY PHYSICIAN RECRUITMENT	A	-15,000	CARDIOLOGY	90.05	0	33.14
33.15	340 EXPENSES	A	-5,474,182	DRUGS CHARGED TO PATIENTS	73.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,295,145				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2025 12:45 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	915,118	929,524	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	228,564	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	26,850	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	CMO EXPENSE - CAMERON WOODS	0	3,300	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	3,450	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - RETAIL PHARMAC	0	74,838	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			915,118	1,266,526	5.00

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

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

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

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

6.00	C	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet A-8-1 Date/Time Prepared: 2/24/2025 12:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-14,406	9		1.00
2.00	-228,564	0		2.00
3.00	-26,850	0		3.00
3.01	-3,300	0		3.01
4.00	-3,450	0		4.00
4.01	-74,838	0		4.01
5.00	-351,408			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2025 12:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	904,409	904,409	0	0	0	1.00
2.00	50.00	OPERATING ROOM	641,174	641,174	0	0	0	2.00
3.00	60.00	LABORATORY	18,157	5,992	12,165	0	0	3.00
4.00	90.01	CLINIC- ORTHO	1,733,798	1,733,798	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP GI	1,422,208	1,422,208	0	0	0	5.00
6.00	90.04	PSYCHIATRY	1,421,035	1,421,035	0	0	0	6.00
7.00	90.05	CARDIOLOGY	692,241	692,241	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	7,875	7,875	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,840,897	6,828,732	12,165		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP GI	0	0	0	0	0	5.00
6.00	90.04	PSYCHIATRY	0	0	0	0	0	6.00
7.00	90.05	CARDIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	904,409		1.00
2.00	50.00	OPERATING ROOM	0	0	0	641,174		2.00
3.00	60.00	LABORATORY	0	0	0	5,992		3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	1,733,798		4.00
5.00	90.02	CLINIC - PEDS ENT FP GI	0	0	0	1,422,208		5.00
6.00	90.04	PSYCHIATRY	0	0	0	1,421,035		6.00
7.00	90.05	CARDIOLOGY	0	0	0	692,241		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,875		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,828,732		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,522,842	3,522,842				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,207,373		3,207,373			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,973,597	28,855	17,109	13,019,561		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,734,281	292,836	343,014	3,143,534	17,513,665	5.00
7.00	00700	OPERATION OF PLANT	4,197,984	345,920	205,105	581,070	5,330,079	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	163,141	36,395	21,579	0	221,115	8.00
9.00	00900	HOUSEKEEPING	1,592,501	6,169	3,658	347,980	1,950,308	9.00
10.00	01000	DIETARY	789,081	203,529	120,678	204,150	1,317,438	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	512,916	22,618	13,411	182,793	731,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	536,204	106,785	63,316	134,630	840,935	14.00
15.00	01500	PHARMACY	873,974	39,582	23,469	177,360	1,114,385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345,942	0	5,222	351,616	1,702,780	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,607,305	639,885	379,405	1,562,736	7,189,331	30.00
31.00	03100	INTENSIVE CARE UNIT	58,865	40,438	23,977	20,301	143,581	31.00
43.00	04300	NURSERY	17,252	14,393	8,534	5,403	45,582	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,079,323	376,352	223,149	409,412	3,088,236	50.00
51.00	05100	RECOVERY ROOM	944,141	243,556	144,411	361,901	1,694,009	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	96,560	60,144	35,661	35,260	227,625	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,843,945	288,176	170,867	1,000,632	5,303,620	54.00
60.00	06000	LABORATORY	3,901,408	95,065	56,366	545,507	4,598,346	60.00
65.00	06500	RESPIRATORY THERAPY	1,198,590	25,017	14,833	376,459	1,614,899	65.00
65.01	06501	SLEEP LAB	116,412	0	57,951	26,337	200,700	65.01
66.00	06600	PHYSICAL THERAPY	1,547,307	216,312	128,257	575,625	2,467,501	66.00
69.00	06900	ELECTROCARDIOLOGY	99,872	12,920	7,660	35,374	155,826	69.00
69.01	06901	CARDIAC REHABILITATION	90,182	21,590	12,801	31,590	156,163	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	850,285	0	0	0	850,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,984,356	0	0	0	1,984,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,947,824	0	0	0	1,947,824	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	2,254,895	0	225,547	0	2,480,442	76.01
76.02	03030	DIABETIC EDUCATION	87,754	0	0	0	87,754	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,317,967	0	137,949	134,700	1,590,616	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,297,615	0	132,666	286,044	2,716,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,507,555	0	71,037	129,160	1,707,752	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,226,069	0	0	119,092	1,345,161	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,101,003	0	0	150,185	1,251,188	88.04
90.00	09000	CLINIC	128,933	13,708	16,886	41,540	201,067	90.00
90.01	09001	CLINIC- ORTHO	535,576	0	80,790	120,985	737,351	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	1,283,569	0	121,511	238,700	1,643,780	90.02
90.03	09003	INTRAVENOUS THERAPY	3,380,979	41,124	24,383	35,171	3,481,657	90.03
90.04	09004	PSYCHIATRY	692,349	0	35,905	208,143	936,397	90.04
90.05	09005	CARDIOLOGY	388,679	0	29,910	111,886	530,475	90.05
91.00	09100	EMERGENCY	2,820,675	327,072	193,929	879,937	4,221,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,857,081	3,498,441	3,150,946	12,565,213	85,321,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	19,877	11,785	0	31,662	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	2,052	0	2,052	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	65,234	0	0	13,805	79,039	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,046,616	0	20,665	113,023	1,180,304	194.05
194.06	07956	GUEST MEALS	59,638	0	0	10,745	70,383	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I Date/Time Prepared: 2/24/2025 12:45 pm

		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	
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	127,847	0	0	46,003	173,850	194.12
194.13	07963	OCCUPATIONAL HEALTH	542,859	0	17,211	154,372	714,442	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	405,595	4,524	4,714	62,866	477,699	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	121,561	0	0	39,723	161,284	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	234,044	0	0	13,811	247,855	194.18
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)	88,460,475	3,522,842	3,207,373	13,019,561	88,460,475	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		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	17,513,665					5.00
7.00	00700	OPERATION OF PLANT	1,315,762	6,645,841				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,584	84,712	360,411			8.00
9.00	00900	HOUSEKEEPING	481,445	14,358	0	2,446,111		9.00
10.00	01000	DIETARY	325,217	473,734	0	49,567	2,165,956	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	180,634	52,646	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,590	248,553	0	8,181	0	14.00
15.00	01500	PHARMACY	275,093	92,131	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	420,341	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,774,749	1,489,402	329,047	68,816	2,137,839	30.00
31.00	03100	INTENSIVE CARE UNIT	35,444	94,125	4,328	0	28,117	31.00
43.00	04300	NURSERY	11,252	33,502	22,854	167,951	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762,350	875,998	0	438,886	0	50.00
51.00	05100	RECOVERY ROOM	418,176	566,902	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,191	139,991	4,182	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,309,230	670,758	0	196,343	0	54.00
60.00	06000	LABORATORY	1,135,129	221,273	0	79,885	0	60.00
65.00	06500	RESPIRATORY THERAPY	398,648	58,230	0	24,543	0	65.00
65.01	06501	SLEEP LAB	49,544	0	0	33,686	0	65.01
66.00	06600	PHYSICAL THERAPY	609,117	503,487	0	127,046	0	66.00
69.00	06900	ELECTROCARDIOLOGY	38,467	30,072	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	38,550	50,253	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,898	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	489,850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,832	0	0	25,505	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	612,312	0	0	103,946	0	76.01
76.02	03030	DIABETIC EDUCATION	21,663	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	392,653	0	0	76,997	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	670,541	0	0	140,039	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	421,569	0	0	33,686	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	332,061	0	0	96,247	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	308,863	0	0	86,622	0	88.04
90.00	09000	CLINIC	49,635	31,907	0	30,799	0	90.00
90.01	09001	CLINIC- ORTHO	182,020	0	0	69,298	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	405,777	0	0	48,605	0	90.02
90.03	09003	INTRAVENOUS THERAPY	859,468	95,720	0	0	0	90.03
90.04	09004	PSYCHIATRY	231,155	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	130,951	0	0	43,792	0	90.05
91.00	09100	EMERGENCY	1,042,130	761,293	0	418,673	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,738,891	6,589,047	360,411	2,369,113	2,165,956	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7,816	46,265	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	507	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	19,511	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	291,365	0	0	0	0	194.05
194.06	07956	GUEST MEALS	17,374	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	42,916	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	176,364	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.15	07965	FOUNDATION	117,923	10,529	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	12,031	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	39,814	0	0	64,967	0	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	61,184	0	0	0	0	194.18
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)	17,513,665	6,645,841	360,411	2,446,111	2,165,956	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	965,018				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,305,259			14.00
15.00	01500	PHARMACY	0	0	6,861	1,488,470		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	170	0	2,123,291	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	319,867	93,461	0	127,824	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,044	0	0	2,667	31.00
43.00	04300	NURSERY	0	0	0	0	4,484	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,091	194,167	0	130,000	50.00
51.00	05100	RECOVERY ROOM	0	60,445	0	0	68,487	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,448	0	0	14,079	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	46,497	0	506,960	54.00
60.00	06000	LABORATORY	0	0	1,360	0	308,707	60.00
65.00	06500	RESPIRATORY THERAPY	0	89,253	12,804	0	25,956	65.00
65.01	06501	SLEEP LAB	0	0	0	0	13,185	65.01
66.00	06600	PHYSICAL THERAPY	0	132,859	3,543	0	68,243	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,030	1,699	0	27,653	69.00
69.01	06901	CARDIAC REHABILITATION	0	9,929	460	0	7,555	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	778	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	706,958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,033,147	18,358	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	226,014	76.01
76.02	03030	DIABETIC EDUCATION	0	0	87	0	597	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	12,800	0	20,491	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	76,099	0	41,286	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	5,417	0	21,987	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	12,339	0	21,566	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	8,791	0	14,315	88.04
90.00	09000	CLINIC	0	7,853	6,992	0	6,231	90.00
90.01	09001	CLINIC- ORTHO	0	0	9,276	0	3,946	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	10,163	0	7,494	90.02
90.03	09003	INTRAVENOUS THERAPY	0	7,020	6,249	455,323	118,042	90.03
90.04	09004	PSYCHIATRY	0	0	215	0	4,639	90.04
90.05	09005	CARDIOLOGY	0	38,194	663	0	26,810	90.05
91.00	09100	EMERGENCY	0	193,985	80,557	0	285,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	965,018	1,298,406	1,488,470	2,123,291	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	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	2	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	357	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	1,964	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	3,048	0	0	194.13

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	918	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	501	0	0	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	0	63	0	0	194.18
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)	0	965,018	1,305,259	1,488,470	2,123,291	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,530,336	0	13,530,336		30.00
31.00	03100	INTENSIVE CARE UNIT	314,306	0	314,306		31.00
43.00	04300	NURSERY	285,625	0	285,625		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,578,728	0	5,578,728		50.00
51.00	05100	RECOVERY ROOM	2,808,019	0	2,808,019		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,516	0	448,516		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,033,408	0	8,033,408		54.00
60.00	06000	LABORATORY	6,344,700	0	6,344,700		60.00
65.00	06500	RESPIRATORY THERAPY	2,224,333	0	2,224,333		65.00
65.01	06501	SLEEP LAB	297,115	0	297,115		65.01
66.00	06600	PHYSICAL THERAPY	3,911,796	0	3,911,796		66.00
69.00	06900	ELECTROCARDIOLOGY	257,747	0	257,747		69.00
69.01	06901	CARDIAC REHABILITATION	262,910	0	262,910		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060,961	0	1,060,961		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,181,164	0	3,181,164		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,505,666	0	3,505,666		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	3,422,714	0	3,422,714		76.01
76.02	03030	DIABETIC EDUCATION	110,101	0	110,101		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,093,557	0	2,093,557		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644,290	0	3,644,290		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,190,411	0	2,190,411		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,807,374	0	1,807,374		88.03
88.04	08804	RURAL HEALTH CLINIC V	1,669,779	0	1,669,779		88.04
90.00	09000	CLINIC	334,484	0	334,484		90.00
90.01	09001	CLINIC- ORTHO	1,001,891	0	1,001,891		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,115,819	0	2,115,819		90.02
90.03	09003	INTRAVENOUS THERAPY	5,023,479	0	5,023,479		90.03
90.04	09004	PSYCHIATRY	1,172,406	0	1,172,406		90.04
90.05	09005	CARDIOLOGY	770,885	0	770,885		90.05
91.00	09100	EMERGENCY	7,003,966	0	7,003,966		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,406,486	0	84,406,486		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	85,743	0	85,743		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,559	0	2,559		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	98,552	0	98,552		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	1,472,026	0	1,472,026		194.05
194.06	07956	GUEST MEALS	87,757	0	87,757		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part I | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.12	07962	TRINE STUDENT HEALTH	218,730	0	218,730		194.12
194.13	07963	OCCUPATIONAL HEALTH	893,854	0	893,854		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	607,069	0	607,069		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	12,031	0	12,031		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	266,566	0	266,566		194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	309,102	0	309,102		194.18
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	88,460,475	0	88,460,475		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	28,855	17,109	45,964	45,964	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	292,836	343,014	635,850	11,103	5.00
7.00	00700	OPERATION OF PLANT	0	345,920	205,105	551,025	2,051	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,395	21,579	57,974	0	8.00
9.00	00900	HOUSEKEEPING	0	6,169	3,658	9,827	1,228	9.00
10.00	01000	DIETARY	0	203,529	120,678	324,207	721	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,618	13,411	36,029	645	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	106,785	63,316	170,101	475	14.00
15.00	01500	PHARMACY	0	39,582	23,469	63,051	626	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	5,222	5,222	1,241	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	639,885	379,405	1,019,290	5,516	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,438	23,977	64,415	72	31.00
43.00	04300	NURSERY	0	14,393	8,534	22,927	19	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	376,352	223,149	599,501	1,445	50.00
51.00	05100	RECOVERY ROOM	0	243,556	144,411	387,967	1,277	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	60,144	35,661	95,805	124	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	288,176	170,867	459,043	3,532	54.00
60.00	06000	LABORATORY	0	95,065	56,366	151,431	1,926	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,017	14,833	39,850	1,329	65.00
65.01	06501	SLEEP LAB	0	0	57,951	57,951	93	65.01
66.00	06600	PHYSICAL THERAPY	0	216,312	128,257	344,569	2,032	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,920	7,660	20,580	125	69.00
69.01	06901	CARDIAC REHABILITATION	0	21,590	12,801	34,391	112	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	225,547	225,547	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	137,949	137,949	475	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	132,666	132,666	1,010	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	71,037	71,037	456	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	420	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	530	88.04
90.00	09000	CLINIC	0	13,708	16,886	30,594	147	90.00
90.01	09001	CLINIC- ORTHO	0	0	80,790	80,790	427	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	121,511	121,511	843	90.02
90.03	09003	INTRAVENOUS THERAPY	0	41,124	24,383	65,507	124	90.03
90.04	09004	PSYCHIATRY	0	0	35,905	35,905	735	90.04
90.05	09005	CARDIOLOGY	0	0	29,910	29,910	395	90.05
91.00	09100	EMERGENCY	0	327,072	193,929	521,001	3,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,498,441	3,150,946	6,649,387	44,360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	19,877	11,785	31,662	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	2,052	2,052	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	49	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	20,665	20,665	399	194.05
194.06	07956	GUEST MEALS	0	0	0	0	38	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	162	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	17,211	17,211	545	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	4,524	4,714	9,238	222	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	140	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	0	0	0	49	194.18
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,522,842	3,207,373	6,730,215	45,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II | Date/Time Prepared: 2/24/2025 12:45 pm

		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	646,953					5.00
7.00	00700	OPERATION OF PLANT	48,605	601,681				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,016	7,669	67,659			8.00
9.00	00900	HOUSEKEEPING	17,785	1,300	0	30,140		9.00
10.00	01000	DIETARY	12,014	42,890	0	611	380,443	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,673	4,766	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,668	22,503	0	101	0	14.00
15.00	01500	PHARMACY	10,162	8,341	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,528	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,547	134,842	61,772	848	375,504	30.00
31.00	03100	INTENSIVE CARE UNIT	1,309	8,522	812	0	4,939	31.00
43.00	04300	NURSERY	416	3,033	4,290	2,069	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,162	79,308	0	5,409	0	50.00
51.00	05100	RECOVERY ROOM	15,448	51,324	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,076	12,674	785	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,364	60,727	0	2,419	0	54.00
60.00	06000	LABORATORY	41,932	20,033	0	984	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,726	5,272	0	302	0	65.00
65.01	06501	SLEEP LAB	1,830	0	0	415	0	65.01
66.00	06600	PHYSICAL THERAPY	22,501	45,583	0	1,565	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,421	2,723	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,424	4,550	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,754	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,095	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,762	0	0	314	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	22,619	0	0	1,281	0	76.01
76.02	03030	DIABETIC EDUCATION	800	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,505	0	0	949	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	24,770	0	0	1,726	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,573	0	0	415	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	12,267	0	0	1,186	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	11,410	0	0	1,067	0	88.04
90.00	09000	CLINIC	1,834	2,889	0	379	0	90.00
90.01	09001	CLINIC- ORTHO	6,724	0	0	854	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	14,990	0	0	599	0	90.02
90.03	09003	INTRAVENOUS THERAPY	31,749	8,666	0	0	0	90.03
90.04	09004	PSYCHIATRY	8,539	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	4,837	0	0	540	0	90.05
91.00	09100	EMERGENCY	38,497	68,924	0	5,159	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	618,332	596,539	67,659	29,192	380,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	289	4,189	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	19	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	721	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	10,763	0	0	0	0	194.05
194.06	07956	GUEST MEALS	642	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	1,585	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	6,515	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.15	07965	FOUNDATION	4,356	953	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	148	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	1,471	0	0	800	0	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	2,260	0	0	0	0	194.18
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)	646,953	601,681	67,659	30,140	380,443	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II | Date/Time Prepared: 2/24/2025 12:45 pm

		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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	48,113				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	200,848			14.00
15.00	01500	PHARMACY	0	0	1,056	83,236		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	26	0	22,017	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,948	14,381	0	1,331	30.00
31.00	03100	INTENSIVE CARE UNIT	0	301	0	0	28	31.00
43.00	04300	NURSERY	0	0	0	0	47	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,442	29,878	0	1,354	50.00
51.00	05100	RECOVERY ROOM	0	3,014	0	0	713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	321	0	0	147	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,155	0	5,182	54.00
60.00	06000	LABORATORY	0	0	209	0	3,216	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,450	1,970	0	270	65.00
65.01	06501	SLEEP LAB	0	0	0	0	137	65.01
66.00	06600	PHYSICAL THERAPY	0	6,624	545	0	711	66.00
69.00	06900	ELECTROCARDIOLOGY	0	201	261	0	288	69.00
69.01	06901	CARDIAC REHABILITATION	0	495	71	0	79	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	120	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	108,784	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,774	191	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	2,354	76.01
76.02	03030	DIABETIC EDUCATION	0	0	13	0	6	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,970	0	213	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	11,710	0	430	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	833	0	229	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,899	0	225	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	1,353	0	149	88.04
90.00	09000	CLINIC	0	392	1,076	0	65	90.00
90.01	09001	CLINIC- ORTHO	0	0	1,427	0	41	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	1,564	0	78	90.02
90.03	09003	INTRAVENOUS THERAPY	0	350	962	25,462	1,230	90.03
90.04	09004	PSYCHIATRY	0	0	33	0	48	90.04
90.05	09005	CARDIOLOGY	0	1,904	102	0	279	90.05
91.00	09100	EMERGENCY	0	9,671	12,396	0	2,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	48,113	199,794	83,236	22,017	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	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	55	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	302	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	469	0	0	194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	141	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	77	0	0	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	0	10	0	0	194.18
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)	0	48,113	200,848	83,236	22,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,694,979	0	1,694,979		30.00
31.00	03100	INTENSIVE CARE UNIT	80,398	0	80,398		31.00
43.00	04300	NURSERY	32,801	0	32,801		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	749,499	0	749,499		50.00
51.00	05100	RECOVERY ROOM	459,743	0	459,743		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,932	0	111,932		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,422	0	586,422		54.00
60.00	06000	LABORATORY	219,731	0	219,731		60.00
65.00	06500	RESPIRATORY THERAPY	68,169	0	68,169		65.00
65.01	06501	SLEEP LAB	60,426	0	60,426		65.01
66.00	06600	PHYSICAL THERAPY	424,130	0	424,130		66.00
69.00	06900	ELECTROCARDIOLOGY	25,599	0	25,599		69.00
69.01	06901	CARDIAC REHABILITATION	41,122	0	41,122		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,874	0	7,874		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,879	0	126,879		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,041	0	76,041		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	251,801	0	251,801		76.01
76.02	03030	DIABETIC EDUCATION	819	0	819		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	156,061	0	156,061		88.00
88.01	08801	RURAL HEALTH CLINIC II	172,312	0	172,312		88.01
88.02	08802	RURAL HEALTH CLINIC III	88,543	0	88,543		88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,997	0	15,997		88.03
88.04	08804	RURAL HEALTH CLINIC V	14,509	0	14,509		88.04
90.00	09000	CLINIC	37,376	0	37,376		90.00
90.01	09001	CLINIC- ORTHO	90,263	0	90,263		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	139,585	0	139,585		90.02
90.03	09003	INTRAVENOUS THERAPY	134,050	0	134,050		90.03
90.04	09004	PSYCHIATRY	45,260	0	45,260		90.04
90.05	09005	CARDIOLOGY	37,967	0	37,967		90.05
91.00	09100	EMERGENCY	661,730	0	661,730		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,612,018	0	6,612,018		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	36,140	0	36,140		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,071	0	2,071		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	770	0	770		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	31,882	0	31,882		194.05
194.06	07956	GUEST MEALS	680	0	680		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B Part II Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.12	07962	TRINE STUDENT HEALTH	2,049	0	2,049		194.12
194.13	07963	OCCUPATIONAL HEALTH	24,740	0	24,740		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	14,910	0	14,910		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	148	0	148		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	2,488	0	2,488		194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	2,319	0	2,319		194.18
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,730,215	0	6,730,215		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	102,797					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		157,847				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842	842	33,965,956			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,545	16,881	8,200,982	-17,513,665	70,946,810	5.00
7.00	00700	OPERATION OF PLANT	10,094	10,094	1,515,920	0	5,330,079	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	221,115	8.00
9.00	00900	HOUSEKEEPING	180	180	907,824	0	1,950,308	9.00
10.00	01000	DIETARY	5,939	5,939	532,596	0	1,317,438	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	660	476,877	0	731,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	351,227	0	840,935	14.00
15.00	01500	PHARMACY	1,155	1,155	462,704	0	1,114,385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	257	917,311	0	1,702,780	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	18,672	4,076,930	0	7,189,331	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	52,961	0	143,581	31.00
43.00	04300	NURSERY	420	420	14,096	0	45,582	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	10,982	1,068,091	0	3,088,236	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	944,141	0	1,694,009	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	1,755	91,987	0	227,625	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	8,409	2,610,489	0	5,303,620	54.00
60.00	06000	LABORATORY	2,774	2,774	1,423,140	0	4,598,346	60.00
65.00	06500	RESPIRATORY THERAPY	730	730	982,121	0	1,614,899	65.00
65.01	06501	SLEEP LAB	0	2,852	68,710	0	200,700	65.01
66.00	06600	PHYSICAL THERAPY	6,312	6,312	1,501,713	0	2,467,501	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	92,285	0	155,826	69.00
69.01	06901	CARDIAC REHABILITATION	630	630	82,414	0	156,163	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	850,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,984,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,947,824	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	11,100	0	0	2,480,442	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	87,754	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,789	351,411	0	1,590,616	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,529	746,242	0	2,716,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,496	336,958	0	1,707,752	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	310,691	0	1,345,161	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	391,809	0	1,251,188	88.04
90.00	09000	CLINIC	400	831	108,372	0	201,067	90.00
90.01	09001	CLINIC- ORTHO	0	3,976	315,630	0	737,351	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	5,980	622,730	0	1,643,780	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	1,200	91,756	0	3,481,657	90.03
90.04	09004	PSYCHIATRY	0	1,767	543,011	0	936,397	90.04
90.05	09005	CARDIOLOGY	0	1,472	291,893	0	530,475	90.05
91.00	09100	EMERGENCY	9,544	9,544	2,295,615	0	4,221,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,085	155,070	32,780,637	-17,513,665	67,808,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	580	0	0	31,662	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	101	0	0	2,052	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	36,014	0	79,039	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	1,017	294,859	0	1,180,304	194.05
194.06	07956	GUEST MEALS	0	0	28,031	0	70,383	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	120,014	0	173,850	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	402,732	0	714,442	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	232	164,007	0	477,699	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	103,630	0	161,284	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	0	36,032	0	247,855	194.18
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)	3,522,842	3,207,373	13,019,561		17,513,665	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.269891	20.319506	0.383312		0.246856	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			45,964		646,953	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001353		0.009119	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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			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	83,316					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	7,412				8.00
9.00	00900	HOUSEKEEPING	180	0	5,083			9.00
10.00	01000	DIETARY	5,939	0	103	6,856		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	17	0	0	14.00
15.00	01500	PHARMACY	1,155	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	6,767	143	6,767	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	89	0	89	0	31.00
43.00	04300	NURSERY	420	470	349	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	0	912	0	0	50.00
51.00	05100	RECOVERY ROOM	7,107	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	86	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	0	408	0	0	54.00
60.00	06000	LABORATORY	2,774	0	166	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	730	0	51	0	0	65.00
65.01	06501	SLEEP LAB	0	0	70	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,312	0	264	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	630	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	53	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	216	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	160	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	291	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	70	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	200	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	180	0	0	88.04
90.00	09000	CLINIC	400	0	64	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	144	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	101	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	91	0	0	90.05
91.00	09100	EMERGENCY	9,544	0	870	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,604	7,412	4,923	6,856	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	0	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF S ERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
194.13	07963	OCCUPATIONAL HEALTH	0	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	0	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	25	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	135	0	0	194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	0	0	0	0	194.18
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)	6,645,841	360,411	2,446,111	2,165,956	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	79.766683	48.625337	481.233720	315.921237	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	601,681	67,659	30,140	380,443	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.221674	9.128305	5.929569	55.490519	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			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						11.00
13.00	01300	NURSING ADMINISTRATION	298,871					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,663,718				14.00
15.00	01500	PHARMACY	0	19,258	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	478	0	228,005,574		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,065	262,335	0	13,726,778		30.00
31.00	03100	INTENSIVE CARE UNIT	1,872	0	0	286,440		31.00
43.00	04300	NURSERY	0	0	0	481,520		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,592	545,006	0	13,960,437		50.00
51.00	05100	RECOVERY ROOM	18,720	0	0	7,354,669		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,997	0	0	1,511,897		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	130,511	0	54,430,708		54.00
60.00	06000	LABORATORY	0	3,817	0	33,151,510		60.00
65.00	06500	RESPIRATORY THERAPY	27,642	35,939	0	2,787,401		65.00
65.01	06501	SLEEP LAB	0	0	0	1,415,884		65.01
66.00	06600	PHYSICAL THERAPY	41,147	9,944	0	7,328,458		66.00
69.00	06900	ELECTROCARDIOLOGY	1,248	4,770	0	2,969,654		69.00
69.01	06901	CARDIAC REHABILITATION	3,075	1,290	0	811,321		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,185	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,984,356	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,941	1,971,451		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0	24,271,217		76.01
76.02	03030	DIABETIC EDUCATION	0	244	0	64,120		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	35,927	0	2,200,508		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	213,602	0	4,433,599		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	15,204	0	2,361,115		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	34,633	0	2,315,944		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	24,675	0	1,537,276		88.04
90.00	09000	CLINIC	2,432	19,625	0	669,141		90.00
90.01	09001	CLINIC- ORTHO	0	26,037	0	423,747		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	28,526	0	804,819		90.02
90.03	09003	INTRAVENOUS THERAPY	2,174	17,539	3,059	12,676,329		90.03
90.04	09004	PSYCHIATRY	0	603	0	498,148		90.04
90.05	09005	CARDIOLOGY	11,829	1,862	0	2,879,083		90.05
91.00	09100	EMERGENCY	60,078	226,116	0	30,682,400		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	298,871	3,644,482	10,000	228,005,574		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	0	0	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	6	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	1,001	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	0	0	0		194.11

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet B-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
194.12	07962	TRINE STUDENT HEALTH	0	5,512	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	8,556	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0		194.14
194.15	07965	FOUNDATION	0	2,578	0	0		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	1,405	0	0		194.17
194.18	07968	OBGYN CLINIC - FORT WAYNE	0	178	0	0		194.18
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)	965,018	1,305,259	1,488,470	2,123,291		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.228878	0.356266	148.847000	0.009312		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,113	200,848	83,236	22,017		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.160982	0.054821	8.323600	0.000097		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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,530,336		13,530,336	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	314,306		314,306	0	0	31.00
43.00	04300	NURSERY	285,625		285,625	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578,728		5,578,728	0	0	50.00
51.00	05100	RECOVERY ROOM	2,808,019		2,808,019	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,516		448,516	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,033,408		8,033,408	0	0	54.00
60.00	06000	LABORATORY	6,344,700		6,344,700	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,224,333	0	2,224,333	0	0	65.00
65.01	06501	SLEEP LAB	297,115	0	297,115	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,911,796	0	3,911,796	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	257,747		257,747	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	262,910		262,910	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060,961		1,060,961	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,181,164		3,181,164	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,505,666		3,505,666	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,422,714		3,422,714	0	0	76.01
76.02	03030	DIABETIC EDUCATION	110,101		110,101	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,557		2,093,557	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644,290		3,644,290	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,190,411		2,190,411	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,807,374		1,807,374	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,669,779		1,669,779	0	0	88.04
90.00	09000	CLINIC	334,484		334,484	0	0	90.00
90.01	09001	CLINIC- ORTHO	1,001,891		1,001,891	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,115,819		2,115,819	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	5,023,479		5,023,479	0	0	90.03
90.04	09004	PSYCHIATRY	1,172,406		1,172,406	0	0	90.04
90.05	09005	CARDIOLOGY	770,885		770,885	0	0	90.05
91.00	09100	EMERGENCY	7,003,966		7,003,966	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,922,118		4,922,118		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	89,328,604	0	89,328,604	0	0	200.00
201.00		Less Observation Beds	4,922,118		4,922,118		0	201.00
202.00		Total (see instructions)	84,406,486	0	84,406,486	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,362,958		10,362,958			30.00
31.00	03100	INTENSIVE CARE UNIT	286,440		286,440			31.00
43.00	04300	NURSERY	481,520		481,520			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,506,686	12,453,751	13,960,437	0.399610	0.000000	50.00
51.00	05100	RECOVERY ROOM	898,721	6,455,948	7,354,669	0.381801	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,499,108	12,789	1,511,897	0.296658	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,321,773	53,108,935	54,430,708	0.147590	0.000000	54.00
60.00	06000	LABORATORY	2,590,920	30,560,590	33,151,510	0.191385	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,164,713	1,622,688	2,787,401	0.797995	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,415,884	1,415,884	0.209844	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,288,010	6,040,448	7,328,458	0.533782	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	87,087	2,882,567	2,969,654	0.086794	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	20,233	791,088	811,321	0.324052	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	857,176	15,159,033	16,016,209	0.066243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,517	4,553,301	4,824,818	0.659333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,971,451	9,074,542	11,045,993	0.317370	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	24,271,217	24,271,217	0.141019	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	5,000	59,120	64,120	1.717109	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,657	2,192,851	2,200,508			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,433,599	4,433,599			88.01
88.02	08802	RURAL HEALTH CLINIC III	942,416	1,418,699	2,361,115			88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,333	2,309,611	2,315,944			88.03
88.04	08804	RURAL HEALTH CLINIC V	13,037	1,524,239	1,537,276			88.04
90.00	09000	CLINIC	0	669,141	669,141	0.499871	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	423,747	423,747	2.364361	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	804,819	804,819	2.628938	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	12,676,329	12,676,329	0.396288	0.000000	90.03
90.04	09004	PSYCHIATRY	0	498,148	498,148	2.353529	0.000000	90.04
90.05	09005	CARDIOLOGY	200,000	2,679,083	2,879,083	0.267754	0.000000	90.05
91.00	09100	EMERGENCY	490,889	30,191,511	30,682,400	0.228273	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,459	3,258,361	3,363,820	1.463252	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	26,379,104	231,542,039	257,921,143			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,379,104	231,542,039	257,921,143			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
76.02	03030	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- ORTHO	0.000000		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0.000000		90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000		90.03
90.04	09004	PSYCHIATRY	0.000000		90.04
90.05	09005	CARDIOLOGY	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,530,336		13,530,336	0	13,530,336	30.00
31.00	03100	INTENSIVE CARE UNIT	314,306		314,306	0	314,306	31.00
43.00	04300	NURSERY	285,625		285,625	0	285,625	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578,728		5,578,728	0	5,578,728	50.00
51.00	05100	RECOVERY ROOM	2,808,019		2,808,019	0	2,808,019	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,516		448,516	0	448,516	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,033,408		8,033,408	0	8,033,408	54.00
60.00	06000	LABORATORY	6,344,700		6,344,700	0	6,344,700	60.00
65.00	06500	RESPIRATORY THERAPY	2,224,333	0	2,224,333	0	2,224,333	65.00
65.01	06501	SLEEP LAB	297,115	0	297,115	0	297,115	65.01
66.00	06600	PHYSICAL THERAPY	3,911,796	0	3,911,796	0	3,911,796	66.00
69.00	06900	ELECTROCARDIOLOGY	257,747		257,747	0	257,747	69.00
69.01	06901	CARDIAC REHABILITATION	262,910		262,910	0	262,910	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060,961		1,060,961	0	1,060,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,181,164		3,181,164	0	3,181,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,505,666		3,505,666	0	3,505,666	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,422,714		3,422,714	0	3,422,714	76.01
76.02	03030	DIABETIC EDUCATION	110,101		110,101	0	110,101	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,557		2,093,557	0	2,093,557	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644,290		3,644,290	0	3,644,290	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,190,411		2,190,411	0	2,190,411	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,807,374		1,807,374	0	1,807,374	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,669,779		1,669,779	0	1,669,779	88.04
90.00	09000	CLINIC	334,484		334,484	0	334,484	90.00
90.01	09001	CLINIC- ORTHO	1,001,891		1,001,891	0	1,001,891	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,115,819		2,115,819	0	2,115,819	90.02
90.03	09003	INTRAVENOUS THERAPY	5,023,479		5,023,479	0	5,023,479	90.03
90.04	09004	PSYCHIATRY	1,172,406		1,172,406	0	1,172,406	90.04
90.05	09005	CARDIOLOGY	770,885		770,885	0	770,885	90.05
91.00	09100	EMERGENCY	7,003,966		7,003,966	0	7,003,966	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,922,118		4,922,118		4,922,118	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	89,328,604	0	89,328,604	0	89,328,604	200.00
201.00		Less Observation Beds	4,922,118		4,922,118		4,922,118	201.00
202.00		Total (see instructions)	84,406,486	0	84,406,486	0	84,406,486	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,362,958		10,362,958			30.00
31.00	03100	INTENSIVE CARE UNIT	286,440		286,440			31.00
43.00	04300	NURSERY	481,520		481,520			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,506,686	12,453,751	13,960,437	0.399610	0.000000	50.00
51.00	05100	RECOVERY ROOM	898,721	6,455,948	7,354,669	0.381801	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,499,108	12,789	1,511,897	0.296658	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,321,773	53,108,935	54,430,708	0.147590	0.000000	54.00
60.00	06000	LABORATORY	2,590,920	30,560,590	33,151,510	0.191385	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,164,713	1,622,688	2,787,401	0.797995	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,415,884	1,415,884	0.209844	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,288,010	6,040,448	7,328,458	0.533782	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	87,087	2,882,567	2,969,654	0.086794	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	20,233	791,088	811,321	0.324052	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	857,176	15,159,033	16,016,209	0.066243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,517	4,553,301	4,824,818	0.659333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,971,451	9,074,542	11,045,993	0.317370	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	24,271,217	24,271,217	0.141019	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	5,000	59,120	64,120	1.717109	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,657	2,192,851	2,200,508	0.951397	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,433,599	4,433,599	0.821971	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	942,416	1,418,699	2,361,115	0.927702	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,333	2,309,611	2,315,944	0.780405	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	13,037	1,524,239	1,537,276	1.086193	0.000000	88.04
90.00	09000	CLINIC	0	669,141	669,141	0.499871	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	423,747	423,747	2.364361	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	804,819	804,819	2.628938	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	12,676,329	12,676,329	0.396288	0.000000	90.03
90.04	09004	PSYCHIATRY	0	498,148	498,148	2.353529	0.000000	90.04
90.05	09005	CARDIOLOGY	200,000	2,679,083	2,879,083	0.267754	0.000000	90.05
91.00	09100	EMERGENCY	490,889	30,191,511	30,682,400	0.228273	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,459	3,258,361	3,363,820	1.463252	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	26,379,104	231,542,039	257,921,143			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,379,104	231,542,039	257,921,143			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	0.399610		50.00
51.00	05100	RECOVERY ROOM	0.381801		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296658		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147590		54.00
60.00	06000	LABORATORY	0.191385		60.00
65.00	06500	RESPIRATORY THERAPY	0.797995		65.00
65.01	06501	SLEEP LAB	0.209844		65.01
66.00	06600	PHYSICAL THERAPY	0.533782		66.00
69.00	06900	ELECTROCARDIOLOGY	0.086794		69.00
69.01	06901	CARDIAC REHABILITATION	0.324052		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066243		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.659333		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317370		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.141019		76.01
76.02	03030	DIABETIC EDUCATION	1.717109		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.951397		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.821971		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.927702		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.780405		88.03
88.04	08804	RURAL HEALTH CLINIC V	1.086193		88.04
90.00	09000	CLINIC	0.499871		90.00
90.01	09001	CLINIC- ORTHO	2.364361		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2.628938		90.02
90.03	09003	INTRAVENOUS THERAPY	0.396288		90.03
90.04	09004	PSYCHIATRY	2.353529		90.04
90.05	09005	CARDIOLOGY	0.267754		90.05
91.00	09100	EMERGENCY	0.228273		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.463252		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part II Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578,728	749,499	4,829,229	0	0	50.00
51.00	05100	RECOVERY ROOM	2,808,019	459,743	2,348,276	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,516	111,932	336,584	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,033,408	586,422	7,446,986	0	0	54.00
60.00	06000	LABORATORY	6,344,700	219,731	6,124,969	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,224,333	68,169	2,156,164	0	0	65.00
65.01	06501	SLEEP LAB	297,115	60,426	236,689	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,911,796	424,130	3,487,666	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	257,747	25,599	232,148	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	262,910	41,122	221,788	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060,961	7,874	1,053,087	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,181,164	126,879	3,054,285	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,505,666	76,041	3,429,625	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	3,422,714	251,801	3,170,913	0	0	76.01
76.02	03030	DIABETIC EDUCATION	110,101	819	109,282	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,557	156,061	1,937,496	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644,290	172,312	3,471,978	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,190,411	88,543	2,101,868	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,807,374	15,997	1,791,377	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,669,779	14,509	1,655,270	0	0	88.04
90.00	09000	CLINIC	334,484	37,376	297,108	0	0	90.00
90.01	09001	CLINIC- ORTHO	1,001,891	90,263	911,628	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,115,819	139,585	1,976,234	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	5,023,479	134,050	4,889,429	0	0	90.03
90.04	09004	PSYCHIATRY	1,172,406	45,260	1,127,146	0	0	90.04
90.05	09005	CARDIOLOGY	770,885	37,967	732,918	0	0	90.05
91.00	09100	EMERGENCY	7,003,966	661,730	6,342,236	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,922,118	616,604	4,305,514	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	75,198,337	5,420,444	69,777,893	0	0	200.00
201.00		Less Observation Beds	4,922,118	616,604	4,305,514	0	0	201.00
202.00		Total (line 200 minus line 201)	70,276,219	4,803,840	65,472,379	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet C Part II | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,578,728	13,960,437	0.399610		50.00
51.00	05100	RECOVERY ROOM	2,808,019	7,354,669	0.381801		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	448,516	1,511,897	0.296658		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,033,408	54,430,708	0.147590		54.00
60.00	06000	LABORATORY	6,344,700	33,151,510	0.191385		60.00
65.00	06500	RESPIRATORY THERAPY	2,224,333	2,787,401	0.797995		65.00
65.01	06501	SLEEP LAB	297,115	1,415,884	0.209844		65.01
66.00	06600	PHYSICAL THERAPY	3,911,796	7,328,458	0.533782		66.00
69.00	06900	ELECTROCARDIOLOGY	257,747	2,969,654	0.086794		69.00
69.01	06901	CARDIAC REHABILITATION	262,910	811,321	0.324052		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060,961	16,016,209	0.066243		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,181,164	4,824,818	0.659333		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,505,666	11,045,993	0.317370		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000		76.00
76.01	03480	ONCOLOGY	3,422,714	24,271,217	0.141019		76.01
76.02	03030	DIABETIC EDUCATION	110,101	64,120	1.717109		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,093,557	2,200,508	0.951397		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644,290	4,433,599	0.821971		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,190,411	2,361,115	0.927702		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,807,374	2,315,944	0.780405		88.03
88.04	08804	RURAL HEALTH CLINIC V	1,669,779	1,537,276	1.086193		88.04
90.00	09000	CLINIC	334,484	669,141	0.499871		90.00
90.01	09001	CLINIC- ORTHO	1,001,891	423,747	2.364361		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2,115,819	804,819	2.628938		90.02
90.03	09003	INTRAVENOUS THERAPY	5,023,479	12,676,329	0.396288		90.03
90.04	09004	PSYCHIATRY	1,172,406	498,148	2.353529		90.04
90.05	09005	CARDIOLOGY	770,885	2,879,083	0.267754		90.05
91.00	09100	EMERGENCY	7,003,966	30,682,400	0.228273		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,922,118	3,363,820	1.463252		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	75,198,337	246,790,225			200.00
201.00		Less Observation Beds	4,922,118	0			201.00
202.00		Total (line 200 minus line 201)	70,276,219	246,790,225			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part II Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	749,499	13,960,437	0.053687	301,645	16,194	50.00
51.00	05100	RECOVERY ROOM	459,743	7,354,669	0.062510	122,387	7,650	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,932	1,511,897	0.074034	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,422	54,430,708	0.010774	248,884	2,681	54.00
60.00	06000	LABORATORY	219,731	33,151,510	0.006628	432,304	2,865	60.00
65.00	06500	RESPIRATORY THERAPY	68,169	2,787,401	0.024456	203,583	4,979	65.00
65.01	06501	SLEEP LAB	60,426	1,415,884	0.042677	0	0	65.01
66.00	06600	PHYSICAL THERAPY	424,130	7,328,458	0.057874	143,279	8,292	66.00
69.00	06900	ELECTROCARDIOLOGY	25,599	2,969,654	0.008620	18,834	162	69.00
69.01	06901	CARDIAC REHABILITATION	41,122	811,321	0.050685	6,153	312	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,874	16,016,209	0.000492	169,424	83	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,879	4,824,818	0.026297	131,411	3,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,041	11,045,993	0.006884	256,341	1,765	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	251,801	24,271,217	0.010374	0	0	76.01
76.02	03030	DIABETIC EDUCATION	819	64,120	0.012773	2,720	35	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	156,061	2,200,508	0.070920	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,312	4,433,599	0.038865	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	88,543	2,361,115	0.037501	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,997	2,315,944	0.006907	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	14,509	1,537,276	0.009438	0	0	88.04
90.00	09000	CLINIC	37,376	669,141	0.055857	0	0	90.00
90.01	09001	CLINIC- ORTHO	90,263	423,747	0.213012	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	139,585	804,819	0.173437	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	134,050	12,676,329	0.010575	0	0	90.03
90.04	09004	PSYCHIATRY	45,260	498,148	0.090857	0	0	90.04
90.05	09005	CARDIOLOGY	37,967	2,879,083	0.013187	137,240	1,810	90.05
91.00	09100	EMERGENCY	661,730	30,682,400	0.021567	17,070	368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	616,604	3,363,820	0.183305	0	0	92.00
200.00		Total (lines 50 through 199)	5,420,444	246,790,225		2,191,275	50,652	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,960,437	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,354,669	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,511,897	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,430,708	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	33,151,510	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,787,401	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,415,884	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	7,328,458	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,969,654	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	811,321	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,016,209	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,824,818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,045,993	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	24,271,217	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	64,120	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,200,508	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,433,599	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,361,115	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,315,944	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,537,276	0.000000	88.04
90.00	09000	CLINIC	0	0	0	669,141	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	423,747	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	0	804,819	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	12,676,329	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	498,148	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	2,879,083	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	30,682,400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,363,820	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	246,790,225		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	301,645	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	122,387	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	248,884	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	432,304	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	203,583	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	143,279	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,834	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	6,153	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	169,424	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	131,411	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	256,341	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	2,720	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	137,240	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	17,070	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,191,275	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part V Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.399610	0	2,443,273	0	0	50.00
51.00	05100	RECOVERY ROOM	0.381801	0	828,678	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296658	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147590	0	10,760,572	0	0	54.00
60.00	06000	LABORATORY	0.191385	0	4,850,623	97	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.797995	0	490,729	0	0	65.00
65.01	06501	SLEEP LAB	0.209844	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533782	0	1,163,747	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.086794	0	510,048	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.324052	0	203,692	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066243	0	591,021	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.659333	0	859,744	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317370	0	2,199,413	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.141019	0	5,376,875	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.717109	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
90.00	09000	CLINIC	0.499871	0	43,545	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.364361	0	280,125	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2.628938	0	104,874	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.396288	0	4,517,048	13,239	0	90.03
90.04	09004	PSYCHIATRY	2.353529	0	115,294	0	0	90.04
90.05	09005	CARDIOLOGY	0.267754	0	483,179	0	0	90.05
91.00	09100	EMERGENCY	0.228273	0	4,067,454	2,440	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.463252	0	1,074,849	0	0	92.00
200.00		Subtotal (see instructions)		0	40,964,783	15,776	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	40,964,783	15,776	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part V Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	976,356	0		50.00
51.00	05100	RECOVERY ROOM	316,390	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,153	0		54.00
60.00	06000	LABORATORY	928,336	19		60.00
65.00	06500	RESPIRATORY THERAPY	391,599	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	621,187	0		66.00
69.00	06900	ELECTROCARDIOLOGY	44,269	0		69.00
69.01	06901	CARDIAC REHABILITATION	66,007	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,151	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	566,858	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	698,028	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	758,242	0		76.01
76.02	03030	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	21,767	0		90.00
90.01	09001	CLINIC- ORTHO	662,317	0		90.01
90.02	09002	CLINIC - PEDS ENT FP GI	275,707	0		90.02
90.03	09003	INTRAVENOUS THERAPY	1,790,052	5,246		90.03
90.04	09004	PSYCHIATRY	271,348	0		90.04
90.05	09005	CARDIOLOGY	129,373	0		90.05
91.00	09100	EMERGENCY	928,490	557		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,572,775	0		92.00
200.00		Subtotal (see instructions)	12,646,405	5,822		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,646,405	5,822		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part I Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	1,694,979	382,411	1,312,568	4,317	304.05	30.00
31.00	INTENSIVE CARE UNIT	80,398		80,398	89	903.35	31.00
43.00	NURSERY	32,801		32,801	470	69.79	43.00
200.00	Total (lines 30 through 199)	1,808,178		1,425,767	4,876		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	81	24,628	30.00
31.00	INTENSIVE CARE UNIT	2	1,807	31.00
43.00	NURSERY	46	3,210	43.00
200.00	Total (lines 30 through 199)	129	29,645	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part II Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	749,499	13,960,437	0.053687	19,721	1,059	50.00
51.00	05100	RECOVERY ROOM	459,743	7,354,669	0.062510	10,648	666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,932	1,511,897	0.074034	13,950	1,033	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,422	54,430,708	0.010774	52,158	562	54.00
60.00	06000	LABORATORY	219,731	33,151,510	0.006628	71,179	472	60.00
65.00	06500	RESPIRATORY THERAPY	68,169	2,787,401	0.024456	26,818	656	65.00
65.01	06501	SLEEP LAB	60,426	1,415,884	0.042677	0	0	65.01
66.00	06600	PHYSICAL THERAPY	424,130	7,328,458	0.057874	3,698	214	66.00
69.00	06900	ELECTROCARDIOLOGY	25,599	2,969,654	0.008620	3,960	34	69.00
69.01	06901	CARDIAC REHABILITATION	41,122	811,321	0.050685	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,874	16,016,209	0.000492	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,879	4,824,818	0.026297	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,041	11,045,993	0.006884	65,081	448	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	251,801	24,271,217	0.010374	0	0	76.01
76.02	03030	DIABETIC EDUCATION	819	64,120	0.012773	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	156,061	2,200,508	0.070920	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,312	4,433,599	0.038865	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	88,543	2,361,115	0.037501	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,997	2,315,944	0.006907	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	14,509	1,537,276	0.009438	0	0	88.04
90.00	09000	CLINIC	37,376	669,141	0.055857	0	0	90.00
90.01	09001	CLINIC- ORTHO	90,263	423,747	0.213012	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	139,585	804,819	0.173437	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	134,050	12,676,329	0.010575	0	0	90.03
90.04	09004	PSYCHIATRY	45,260	498,148	0.090857	0	0	90.04
90.05	09005	CARDIOLOGY	37,967	2,879,083	0.013187	0	0	90.05
91.00	09100	EMERGENCY	661,730	30,682,400	0.021567	42,841	924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	616,604	3,363,820	0.183305	0	0	92.00
200.00		Total (lines 50 through 199)	5,420,444	246,790,225		310,054	6,068	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part III Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,317	0.00	81	30.00
31.00	03100	INTENSIVE CARE UNIT		0	89	0.00	2	31.00
43.00	04300	NURSERY		0	470	0.00	46	43.00
200.00		Total (lines 30 through 199)		0	4,876		129	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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,960,437	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,354,669	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,511,897	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,430,708	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	33,151,510	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,787,401	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,415,884	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	7,328,458	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,969,654	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	811,321	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,016,209	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,824,818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,045,993	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	24,271,217	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	64,120	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,200,508	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,433,599	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,361,115	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,315,944	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,537,276	0.000000	88.04
90.00	09000	CLINIC	0	0	0	669,141	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	423,747	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0	0	0	804,819	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	12,676,329	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	498,148	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	2,879,083	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	30,682,400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,363,820	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	246,790,225		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D Part IV | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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	19,721	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	10,648	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,950	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,158	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	71,179	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,818	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,698	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,960	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	65,081	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	42,841	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		310,054	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,317	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)	2,289	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	259	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)	994	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	527	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)	91	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)	336	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,530,336	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,556	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)	6,942	25.00
26.00	Total swing-bed cost (see instructions)	3,052,629	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,477,707	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)	10,477,707	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,427.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,279,071	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)	1,279,071	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	314,306	89	3,531.53	21	74,162	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)	753,841	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)	2,107,074	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)	220,864	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	815,499	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,036,363	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)	2,028	87.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,427.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,922,118	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	1,694,979	13,530,336	0.125272	4,922,118	616,604	90.00
91.00	Nursing Program cost	0	13,530,336	0.000000	4,922,118	0	91.00
92.00	Allied health cost	0	13,530,336	0.000000	4,922,118	0	92.00
93.00	All other Medical Education	0	13,530,336	0.000000	4,922,118	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | 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)	5,623	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,317	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)	2,289	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	259	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)	994	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	81	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)	470	15.00
16.00	Nursery days (title V or XIX only)	46	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,530,336	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,556	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)	6,942	25.00
26.00	Total swing-bed cost (see instructions)	3,052,629	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,477,707	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)	10,477,707	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,427.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	196,593	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)	196,593	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	285,625	470	607.71	46	27,955	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	314,306	89	3,531.53	2	7,063	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)	91,558	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)	323,169	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)	29,645	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,068	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	35,713	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	287,456	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)	2,028	87.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-1 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

	Cost Center Description		
		1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,427.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,922,118	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	1,694,979	13,530,336	0.125272	4,922,118	616,604	90.00
91.00	Nursing Program cost	0	13,530,336	0.000000	4,922,118	0	91.00
92.00	Allied health cost	0	13,530,336	0.000000	4,922,118	0	92.00
93.00	All other Medical Education	0	13,530,336	0.000000	4,922,118	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-3 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,015,330		30.00
31.00	03100	INTENSIVE CARE UNIT		65,520		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.399610	301,645	120,540	50.00
51.00	05100	RECOVERY ROOM	0.381801	122,387	46,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296658	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147590	248,884	36,733	54.00
60.00	06000	LABORATORY	0.191385	432,304	82,737	60.00
65.00	06500	RESPIRATORY THERAPY	0.797995	203,583	162,458	65.00
65.01	06501	SLEEP LAB	0.209844	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533782	143,279	76,480	66.00
69.00	06900	ELECTROCARDIOLOGY	0.086794	18,834	1,635	69.00
69.01	06901	CARDIAC REHABILITATION	0.324052	6,153	1,994	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066243	169,424	11,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.659333	131,411	86,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317370	256,341	81,355	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.141019	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.717109	2,720	4,671	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000	CLINIC	0.499871	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.364361	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2.628938	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.396288	0	0	90.03
90.04	09004	PSYCHIATRY	2.353529	0	0	90.04
90.05	09005	CARDIOLOGY	0.267754	137,240	36,747	90.05
91.00	09100	EMERGENCY	0.228273	17,070	3,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.463252	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,191,275	753,841	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)		2,191,275		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-3 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.399610	0	0	50.00
51.00	05100	RECOVERY ROOM	0.381801	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296658	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147590	24,516	3,618	54.00
60.00	06000	LABORATORY	0.191385	73,064	13,983	60.00
65.00	06500	RESPIRATORY THERAPY	0.797995	38,434	30,670	65.00
65.01	06501	SLEEP LAB	0.209844	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533782	337,079	179,927	66.00
69.00	06900	ELECTROCARDIOLOGY	0.086794	3,189	277	69.00
69.01	06901	CARDIAC REHABILITATION	0.324052	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066243	35,667	2,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.659333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317370	89,092	28,275	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.141019	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.717109	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000	CLINIC	0.499871	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.364361	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2.628938	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.396288	0	0	90.03
90.04	09004	PSYCHIATRY	2.353529	0	0	90.04
90.05	09005	CARDIOLOGY	0.267754	0	0	90.05
91.00	09100	EMERGENCY	0.228273	3,297	753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.463252	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		604,338	259,866	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)		604,338		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet D-3 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		148,333		30.00
31.00	03100	INTENSIVE CARE UNIT		9,000		31.00
43.00	04300	NURSERY		10,000		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.399610	19,721	7,881	50.00
51.00	05100	RECOVERY ROOM	0.381801	10,648	4,065	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296658	13,950	4,138	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147590	52,158	7,698	54.00
60.00	06000	LABORATORY	0.191385	71,179	13,623	60.00
65.00	06500	RESPIRATORY THERAPY	0.797995	26,818	21,401	65.00
65.01	06501	SLEEP LAB	0.209844	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533782	3,698	1,974	66.00
69.00	06900	ELECTROCARDIOLOGY	0.086794	3,960	344	69.00
69.01	06901	CARDIAC REHABILITATION	0.324052	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066243	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.659333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317370	65,081	20,655	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.141019	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.717109	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.951397	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.821971	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.927702	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.780405	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.086193	0	0	88.04
90.00	09000	CLINIC	0.499871	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.364361	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP GI	2.628938	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.396288	0	0	90.03
90.04	09004	PSYCHIATRY	2.353529	0	0	90.04
90.05	09005	CARDIOLOGY	0.267754	0	0	90.05
91.00	09100	EMERGENCY	0.228273	42,841	9,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.463252	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		310,054	91,558	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)		310,054		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E Part B Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,652,227	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,652,227	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12,778,749	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	82,111	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7,201,681	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)	5,494,957	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)	5,494,957	30.00
31.00	Primary payer payments	784	31.00
32.00	Subtotal (line 30 minus line 31)	5,494,173	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)	633,188	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	411,572	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	407,903	36.00
37.00	Subtotal (see instructions)	5,905,745	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,905,745	40.00
40.01	Sequestration adjustment (see instructions)	118,115	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	5,286,592	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)	501,038	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet E Part B Date/Time Prepared: 2/24/2025 12:45 pm
	Title XVIII	Hospital	Cost

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,664,154		5,286,592	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/30/2024	150,800		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)		150,800		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)		1,814,954		5,286,592	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		32,242		501,038	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,847,196		5,787,630	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,215,780		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/30/2024	108,500		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)		108,500		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)		1,324,280		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		48,657		0	6.02
7.00	Total Medicare program liability (see instructions)		1,275,623		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		08001		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2023 To 09/30/2024	Worksheet E-1 Part II Date/Time Prepared: 2/24/2025 12:45 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E-2 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,046,727	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)	262,465	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	427	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)	1,309,192	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,309,192	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)	1,309,192	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,536	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,301,656	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)	1,301,656	0	19.00
19.01	Sequestration adjustment (see instructions)	26,033	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	1,324,280	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)	-48,657	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E-3 Part V Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,107,074	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	2,107,074	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,128,145	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,128,145	19.00
20.00	Deductibles (exclude professional component)	254,560	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,873,585	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,873,585	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	17,399	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,309	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,200	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,884,894	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,884,894	30.00
30.01	Sequestration adjustment (see instructions)	37,698	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,814,954	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	32,242	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet E-3 Part VII Date/Time Prepared: 2/24/2025 12:45 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	36,553		8.00
9.00	Ancillary service charges	310,054	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	346,607	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	346,607	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	346,607	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	126,306	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	126,306	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	126,306	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	126,306	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	261	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	126,045	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	126,045	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	126,045	0	40.00
41.00	Interim payments	126,045	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet G | Date/Time Prepared: 2/24/2025 12:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	16,177,026	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,339,325	0	0	0	4.00
5.00	Other receivable	2,484,330	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,822,148	0	0	0	7.00
8.00	Prepaid expenses	1,748,092	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,570,921	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,240,172	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	61,742,281	0	0	0	15.00
16.00	Accumulated depreciation	-38,394,180	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	22,582,763	0	0	0	23.00
24.00	Accumulated depreciation	-16,689,524	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	11,700,491	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	43,182,003	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	44,995,527	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	7,072,405	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52,067,932	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	129,820,856	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,847,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,796,878	0	0	0	38.00
39.00	Payroll taxes payable	76,036	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,251,213	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	572,816	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,544,740	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,678,897	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,678,897	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	56,223,637	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	73,597,219				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)	73,597,219	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	129,820,856	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet G-1 | Date/Time Prepared: 2/24/2025 12:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		60,188,229		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,408,989				2.00
3.00	Total (sum of line 1 and line 2)		73,597,218		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		73,597,219		0		11.00
12.00	ROUNDING	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)		73,597,219		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	ROUNDING		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	ROUNDING		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: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/24/2025 12:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,844,478		10,844,478	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)	10,844,478		10,844,478	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	286,440		286,440	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)	286,440		286,440	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,130,918		11,130,918	17.00
18.00	Ancillary services	14,078,743	201,911,773	215,990,516	18.00
19.00	Outpatient services	200,000	17,751,267	17,951,267	19.00
20.00	RURAL HEALTH CLINIC	7,657	2,192,851	2,200,508	20.00
20.01	RURAL HEALTH CLINIC II	0	4,433,599	4,433,599	20.01
20.02	RURAL HEALTH CLINIC III	942,416	1,418,699	2,361,115	20.02
20.03	RURAL HEALTH CLINIC IV	6,333	2,309,611	2,315,944	20.03
20.04	RURAL HEALTH CLINIC V	13,037	1,524,239	1,537,276	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	0	26.00
27.00	NON REIMBURSABLE	0	0	0	27.00
27.01	PROFESSIONAL FEES	496,880	7,205,072	7,701,952	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,875,984	238,747,111	265,623,095	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		106,755,620		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)		106,755,620		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2023 To 09/30/2024 | Worksheet G-3 | Date/Time Prepared: 2/24/2025 12:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	265,623,095	1.00
2.00	Less contractual allowances and discounts on patients' accounts	161,532,728	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,090,367	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	106,755,620	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,665,253	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	676,408	6.00
7.00	Income from investments	1,069,201	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	344,045	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	4,533,626	24.00
24.01	340B CONTRACT REVENUE	1,877,272	24.01
24.02	PHYISICAN INCENTIVE PAYMENTS	0	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	7,573,690	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	16,074,242	25.00
26.00	Total (line 5 plus line 25)	13,408,989	26.00
27.00	LOSS ON DISPOSAL OF PROPERTY	0	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
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)	13,408,989	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	437,177	27,033	464,210	21,872	486,082	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	249,231	0	249,231	43,164	292,395	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	172,417	0	172,417	0	172,417	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	25,023	0	25,023	0	25,023	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	121,606	0	121,606	0	121,606	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,005,454	27,033	1,032,487	65,036	1,097,523	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	36,051	36,051	0	36,051	15.00
16.00	Transportation (Health Care Staff)	0	3,332	3,332	0	3,332	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,383	39,383	0	39,383	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,005,454	66,416	1,071,870	65,036	1,136,906	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	48,935	48,935	0	48,935	29.00
30.00	Administrative Costs	77,169	54,957	132,126	0	132,126	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	77,169	103,892	181,061	0	181,061	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,082,623	170,308	1,252,931	65,036	1,317,967	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	486,082		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	292,395		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	172,417		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	25,023		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	121,606		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,097,523		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	36,051		15.00
16.00	Transportation (Health Care Staff)	0	3,332		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,383		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,136,906		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	48,935		29.00
30.00	Administrative Costs	0	132,126		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	181,061		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,317,967		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	474,426	0	474,426	64,447	538,873	1.00
2.00	Physician Assistant	225,437	0	225,437	33,314	258,751	2.00
3.00	Nurse Practitioner	364,347	0	364,347	224,295	588,642	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	187,959	0	187,959	0	187,959	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	159,238	0	159,238	0	159,238	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,411,407	0	1,411,407	322,056	1,733,463	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	218,195	218,195	0	218,195	15.00
16.00	Transportation (Health Care Staff)	0	1,819	1,819	0	1,819	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	220,014	220,014	0	220,014	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,411,407	220,014	1,631,421	322,056	1,953,477	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	56,225	56,225	0	56,225	29.00
30.00	Administrative Costs	222,179	65,734	287,913	0	287,913	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	222,179	121,959	344,138	0	344,138	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,633,586	341,973	1,975,559	322,056	2,297,615	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	538,873		1.00
2.00	Physician Assistant	0	258,751		2.00
3.00	Nurse Practitioner	0	588,642		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	187,959		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	159,238		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,733,463		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	218,195		15.00
16.00	Transportation (Health Care Staff)	0	1,819		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	220,014		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,953,477		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	56,225		29.00
30.00	Administrative Costs	0	287,913		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	344,138		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,297,615		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	411,288	273,437	684,725	11,482	696,207	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	261,418	0	261,418	83,102	344,520	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	184,330	0	184,330	0	184,330	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	105,406	0	105,406	0	105,406	9.00
10.00	Subtotal (sum of lines 1 through 9)	962,442	273,437	1,235,879	94,584	1,330,463	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	15,261	15,261	0	15,261	15.00
16.00	Transportation (Health Care Staff)	0	2,850	2,850	0	2,850	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,111	18,111	0	18,111	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	962,442	291,548	1,253,990	94,584	1,348,574	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	70,426	70,426	0	70,426	29.00
30.00	Administrative Costs	97,877	31,451	129,328	0	129,328	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	97,877	101,877	199,754	0	199,754	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,060,319	393,425	1,453,744	94,584	1,548,328	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

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	696,207		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-40,773	303,747		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	184,330		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	105,406		9.00
10.00	Subtotal (sum of lines 1 through 9)	-40,773	1,289,690		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	15,261		15.00
16.00	Transportation (Health Care Staff)	0	2,850		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,111		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-40,773	1,307,801		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	70,426		29.00
30.00	Administrative Costs	0	129,328		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	199,754		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-40,773	1,507,555		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315
Component CCN: 15-8570

Period: From 10/01/2023 To 09/30/2024

Worksheet M-1
Date/Time Prepared: 2/24/2025 12:45 pm

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	392,021	0	392,021	50,238	442,259	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	229,372	0	229,372	149,510	378,882	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	120,459	0	120,459	0	120,459	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	123,672	0	123,672	0	123,672	9.00
10.00	Subtotal (sum of lines 1 through 9)	865,524	0	865,524	199,748	1,065,272	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	36,597	36,597	0	36,597	15.00
16.00	Transportation (Health Care Staff)	0	3,565	3,565	0	3,565	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,162	40,162	0	40,162	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	865,524	40,162	905,686	199,748	1,105,434	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	37,942	37,942	5,232	43,174	29.00
30.00	Administrative Costs	75,633	50,912	126,545	0	126,545	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	75,633	88,854	164,487	5,232	169,719	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	941,157	129,016	1,070,173	204,980	1,275,153	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-49,084	393,175		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	378,882		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	120,459		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	123,672		9.00
10.00	Subtotal (sum of lines 1 through 9)	-49,084	1,016,188		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	36,597		15.00
16.00	Transportation (Health Care Staff)	0	3,565		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,162		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-49,084	1,056,350		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	43,174		29.00
30.00	Administrative Costs	0	126,545		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	169,719		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-49,084	1,226,069		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC V | 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	506,600	0	506,600	35,305	541,905	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	104,551	0	104,551	13,894	118,445	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	200,203	0	200,203	0	200,203	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	19,170	0	19,170	0	19,170	9.00
10.00	Subtotal (sum of lines 1 through 9)	830,524	0	830,524	49,199	879,723	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	24,179	24,179	0	24,179	15.00
16.00	Transportation (Health Care Staff)	0	2,647	2,647	0	2,647	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	26,826	26,826	0	26,826	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	830,524	26,826	857,350	49,199	906,549	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	45,980	45,980	9,972	55,952	29.00
30.00	Administrative Costs	91,776	46,726	138,502	0	138,502	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	91,776	92,706	184,482	9,972	194,454	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	922,300	119,532	1,041,832	59,171	1,101,003	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-1 | Date/Time Prepared: 2/24/2025 12:45 pm

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	541,905		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	118,445		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	200,203		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	19,170		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	879,723		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	24,179		15.00
16.00	Transportation (Health Care Staff)	0	2,647		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	26,826		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	906,549		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	55,952		29.00
30.00	Administrative Costs	0	138,502		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	194,454		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,101,003		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-2 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.60	3,089	4,200	2,520		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.50	5,351	2,100	3,150		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.10	8,440		5,670	8,440	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.17	237			237	6.00
7.00	Clinical Social Worker	0.15	201			201	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)	2.42	8,878			8,878	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,136,906	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,136,906	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)	181,061	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	775,590	15.00
16.00	Total overhead (sum of lines 14 and 15)	956,651	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	956,651	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	956,651	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,093,557	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-2 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.02	3,251	4,200	4,284		1.00
2.00	Physician Assistant	1.14	6,531	2,100	2,394		2.00
3.00	Nurse Practitioner	1.02	10,697	2,100	2,142		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.18	20,479		8,820	20,479	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)	3.18	20,479			20,479	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,953,477	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,953,477	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)	344,138	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,346,675	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,690,813	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,690,813	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,690,813	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,644,290	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-2 | Date/Time Prepared: 2/24/2025 12:45 pm

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	0.29	2,580	4,200	1,218		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	4,530	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.20	7,110		3,129	7,110	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)	1.20	7,110			7,110	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,307,801	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,307,801	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)	199,754	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	682,856	15.00
16.00	Total overhead (sum of lines 14 and 15)	882,610	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	882,610	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	882,610	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,190,411	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-2 | Date/Time Prepared: 2/24/2025 12:45 pm

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	0.78	4,328	4,200	3,276		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.31	4,490	2,100	2,751		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.09	8,818		6,027	8,818	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)	2.09	8,818			8,818	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,056,350	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,056,350	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)	169,719	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	581,305	15.00
16.00	Total overhead (sum of lines 14 and 15)	751,024	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	751,024	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	751,024	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,807,374	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-2 | Date/Time Prepared: 2/24/2025 12:45 pm

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	1.52	4,939	4,200	6,384		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.66	1,714	2,100	1,386		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.18	6,653		7,770	7,770	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)	2.18	6,653			7,770	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)	906,549	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)	906,549	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)	194,454	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	568,776	15.00
16.00	Total overhead (sum of lines 14 and 15)	763,230	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	763,230	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	763,230	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,669,779	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/24/2025 12:45 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,093,557	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		64,309	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,029,248	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,878	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)		8,878	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		228.57	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2023 through 12/31/2023)	Rate Period 2 (01/01/2024 through 09/30/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	285.75	298.89	8.00
9.00	Rate for Program covered visits (see instructions)	228.57	228.57	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	273	812	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	62,400	185,599	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	247,999	16.00
16.01	Total program charges (see instructions)(from contractor's records)		241,900	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,850	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,998	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.)		174,239	16.04
16.05	Total program cost (see instructions)	0	180,237	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,202	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		42,324	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		180,237	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		55,430	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)		235,667	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)		235,667	26.00
26.01	Sequestration adjustment (see instructions)		4,713	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		166,566	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)		64,388	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: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-3 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | RHC II | Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,644,290	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)		3,644,290	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		20,479	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)		20,479	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		177.95	7.00
		Calculation of Limit (1)		
		Rate Period 1 (10/01/2023 through 12/31/2023)	Rate Period 2 (01/01/2024 through 09/30/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	237.29	248.21	8.00
9.00	Rate for Program covered visits (see instructions)	177.95	177.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	291	865	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,783	153,927	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	205,710	16.00
16.01	Total program charges (see instructions)(from contractor's records)		227,727	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.)		145,746	16.04
16.05	Total program cost (see instructions)	0	145,746	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,528	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,840	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		145,746	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)		145,746	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)		145,746	26.00
26.01	Sequestration adjustment (see instructions)		2,915	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		135,615	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)		7,216	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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/24/2025 12:45 pm
	Title XVIII	RHC III	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,190,411	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	7,195	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,183,216	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	7,110	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)	7,110	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	307.06	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2023 through 12/31/2023)	Rate Period 2 (01/01/2024 through 09/30/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	478.80	500.82	8.00
9.00	Rate for Program covered visits (see instructions)	307.06	307.06	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	28	85	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	8,598	26,100	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	34,698	16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,506	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,666	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,459	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.)		24,641	16.04
16.05	Total program cost (see instructions)	0	27,100	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,438	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,080	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		27,100	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		316	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)		27,416	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)		27,416	26.00
26.01	Sequestration adjustment (see instructions)		548	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		28,291	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)		-1,423	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: 15-1315 Component CCN: 15-8570	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/24/2025 12:45 pm
	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)		1,807,374	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		80,831	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,726,543	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,818	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)		8,818	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		195.80	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2023 through 12/31/2023)	Rate Period 2 (01/01/2024 through 09/30/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	126.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)	126.00	139.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	292	868	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	36,792	120,652	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	157,444	16.00
16.01	Total program charges (see instructions)(from contractor's records)		257,428	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,653	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,515	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.)		103,606	16.04
16.05	Total program cost (see instructions)	0	110,121	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,421	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,072	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		110,121	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		65,677	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)		175,798	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)		175,798	26.00
26.01	Sequestration adjustment (see instructions)		3,516	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		106,886	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)		65,396	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: 15-1315 Component CCN: 15-8571	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/24/2025 12:45 pm
	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)		1,669,779	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		50,025	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,619,754	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,770	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)		7,770	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		208.46	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2023 through 12/31/2023)	Rate Period 2 (01/01/2024 through 09/30/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	126.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)	126.00	139.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	243	723	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	30,618	100,497	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	131,115	16.00
16.01	Total program charges (see instructions)(from contractor's records)		200,003	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,180	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,640	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.)		83,272	16.04
16.05	Total program cost (see instructions)	0	91,912	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,385	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,688	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		91,912	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		40,531	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)		132,443	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)		132,443	26.00
26.01	Sequestration adjustment (see instructions)		2,649	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		89,805	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)		39,989	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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-4 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,097,523	1,097,523	1,097,523	1,097,523	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000267	0.001498	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	293	1,644	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,873	16,113	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,166	17,757	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,136,906	1,136,906	1,136,906	1,136,906	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	956,651	956,651	956,651	956,651	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015099	0.015619	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	14,444	14,942	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,610	32,699	0	0	10.00
11.00	Total number of injections/infusions (from your records)	68	382	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	464.85	85.60	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	64	300	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)	29,750	25,680	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)		64,309	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)		55,430	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-4 | Date/Time Prepared: 2/24/2025 12:45 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,289,690	1,289,690	1,289,690	1,289,690	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000355	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	458	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	3,838	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,296	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,307,801	1,307,801	1,307,801	1,307,801	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	882,610	882,610	882,610	882,610	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003285	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,899	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	7,195	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	91	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	79.07	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	4	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	316	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)		7,195	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)		316	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8570 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-4 | Date/Time Prepared: 2/24/2025 12:45 pm

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)	1,016,188	1,016,188	1,016,188	1,016,188	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000277	0.002823	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	281	2,869	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,128	27,965	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16,409	30,834	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,056,350	1,056,350	1,056,350	1,056,350	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	751,024	751,024	751,024	751,024	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015534	0.029189	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,666	21,922	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	28,075	52,756	0	0	10.00
11.00	Total number of injections/infusions (from your records)	65	663	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	431.92	79.57	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	57	516	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)	24,619	41,058	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)		80,831	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)		65,677	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8571 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-4 | Date/Time Prepared: 2/24/2025 12:45 pm

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)	879,723	879,723	879,723	879,723	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000080	0.002312	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	70	2,034	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,218	20,837	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,288	22,871	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	906,549	906,549	906,549	906,549	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	763,230	763,230	763,230	763,230	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004730	0.025229	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,610	19,256	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	7,898	42,127	0	0	10.00
11.00	Total number of injections/infusions (from your records)	17	494	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	464.59	85.28	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	14	399	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)	6,504	34,027	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)		50,025	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)		40,531	16.00

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

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2023 To 09/30/2024 | Worksheet M-5 | Date/Time Prepared: 2/24/2025 12:45 pm

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		166,566	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)		166,566	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		64,388	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		230,954	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8545	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/24/2025 12:45 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		135,615	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)		135,615	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		7,216	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		142,831	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8546	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/24/2025 12:45 pm

		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		28,291	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)		28,291	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,423	6.02
7.00	Total Medicare program liability (see instructions)		26,868	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8570	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/24/2025 12:45 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		106,886	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)		106,886	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		65,396	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		172,282	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: 15-1315 Component CCN: 15-8571	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/24/2025 12:45 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		89,805	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)		89,805	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		39,989	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		129,794	7.00

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