

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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S Parts I-III Date/Time Prepared: 2/25/2025 3:44 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 2/25/2025	Time: 3:44 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 PULASKI MEMORIAL HOSPITAL (15-1305) 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	Gregg Malott	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	Gregg Malott		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	86,643	-328,709	0	12,932 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	123,135	0	0	0 5.00
6.00	SWING BED - NF	0			0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0		288,835	0	0 10.00
10.01	RURAL HEALTH CLINIC II	0		55,224	0	0 10.01
10.02	RURAL HEALTH CLINIC III	0		-41,041	0	0 10.02
10.03	RURAL HEALTH CLINIC IV	0		40,763	0	0 10.03
10.04	RURAL HEALTH CLINIC V	0		284	0	0 10.04
200.00	TOTAL	0	209,778	15,356	0	12,932 200.00

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: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet S-2 Part I Date/Time Prepared: 2/25/2025 3:44 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 616 EAST 13TH		PO Box:									
2.00 City: WINAMAC		State: IN		Zip Code: 46996-		County: PULASKI					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00		
		V		XVIII		XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	0	0	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		PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	0	P	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		PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	0	N	15.00
15.01	Hospital-Based Health Clinic - RHC I I		PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	0	N	15.01
15.02	Hospital-Based Health Clinic - RHC I I I		PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	0	N	15.02
15.03	Hospital-Based Health Clinic - RHC I V		PULASKI MEMORIAL RHC - KNOX MEDICAL	158554	99915		07/06/2020	N	0	N	15.03
15.04	Hospital-Based Health Clinic - RHC V		PULASKI MEMORIAL RHC - CULVER	158581	99915		04/30/2024	N	0	N	15.04
16.00	Hospital-Based Health Clinic - FOHC										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: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet S-2 Part I Date/Time Prepared: 2/25/2025 3:44 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	0		25.00
		Urban/Rural		S	Date of Geogr				
		1.00		2.00	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					
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					
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					
		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.								
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					
37.01	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)								
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.								
		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					
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					
		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	

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

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

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

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			1.00	
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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
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		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	

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 2/25/2025 3:44 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			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. 1? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 2/25/2025 3:44 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		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:	211,013	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
DO NOT USE THIS LINE				
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	119.00 120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 2/25/2025 3:44 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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet S-2 Part II Date/Time Prepared: 2/25/2025 3:44 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	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)	Y	01/08/2025	Y	01/08/2025		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)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-2 Part II Date/Time Prepared: 2/25/2025 3:44 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 relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-1305

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

Worksheet S-2
Part II
Date/Time Prepared:
2/25/2025 3:44 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai l ab l e	CAH/REH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Ti t l e 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	25	9,150	18,600.00	0	1.00	
2.00 HMO and other (see instructions)						2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	18,600.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY	43.00				0	13.00	
14.00 Total (see instructions)		25	9,150	18,600.00	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: 15-1305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	378	7	775		1.00
2.00	HMO and other (see instructions)	279	29			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	277	0	277		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	185		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	655	7	1,237		7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	0		13.00
14.00	Total (see instructions)	655	7	1,237	0.00	209.22
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
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	0	0	0	0.00	0.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	6,215	5,726	24,807	0.00	29.35
26.01	RURAL HEALTH CLINIC II	832	536	3,358	0.00	1.41
26.02	RURAL HEALTH CLINIC III	410	254	1,784	0.00	0.69
26.03	RURAL HEALTH CLINIC IV	961	855	4,251	0.00	3.37
26.04	RURAL HEALTH CLINIC V	169	263	1,014	0.00	0.98
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	245.02
28.00	Observation Bed Days		22	516		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	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care					34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
	Nonpaid Workers	Title V	Title XVIII	Title XIX			
	11.00	12.00	13.00	14.00			15.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	117	3	251	1.00
2.00	HMO and other (see instructions)			90	9		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	117	3	251	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: 15-1305 Component CCN: 15-8512	Period: From 10/01/2023 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm	
			RHC I	Cost	
			1.00		
1.00	Clinic Address and Identification Street		540 HOSPITAL DRIVE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		WINNIAC IN 46996-		2.00
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) CLINIC		08:00	17:00	08:00
		1.00	2.00	3.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.		N 0		13.00
			Provider name		CCN
			1.00		2.00
14.00	RHC/FQHC name, CCN				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
					Total Visits
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		PULASKI		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8512		Period: From 10/01/2023 To 09/30/2024		Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm	
		RHC I		Cost			
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1) CLINIC	17:30	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2023 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm	
			RHC II	Cost	
			1.00		
1.00	Clinic Address and Identification Street	NORTH LANE STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON IN		46366-1226 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) CLINIC	08:00		17:00	08:00 11.00
		1.00		2.00	
		3.00		4.00	
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
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County	PULASKI		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8527

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

Worksheet S-8
Date/Time Prepared:
2/25/2025 3:44 pm

		Tuesday		Wednesday		Thursday		
		to	from	to	from	to	to	
		6.00	7.00	8.00	9.00	10.00		
	Facility hours of operations (1)							
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00		11.00
		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
11.00	CLINIC	08:00	17:00					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2023 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm
			RHC III	Cost
			1.00	
1.00	Clinic Address and Identification Street	112 E MONTGOMERY STREET		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	FRANCESVILLE	IN	47946-8087 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	
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		Tuesday
		from	to	from
		1.00	2.00	3.00
		Monday		
		from	to	
		3.00	4.00	
11.00	Facility hours of operations (1) CLINIC	08:00	17:00	09:00 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
		1.00	2.00	3.00
			XIX	Total Visits
			4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00
			County	
			4.00	
2.00	City, State, ZIP Code, County	PULASKI		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8528

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

Worksheet S-8
Date/Time Prepared:
2/25/2025 3:44 pm

		Tuesday		Wednesday		Thursday		
		to	from	to	from	to	to	
		6.00	7.00	8.00	9.00	10.00		
	Facility hours of operations (1)							
11.00	CLINIC	19:00	08:00	16:00	08:00	16:00		11.00
		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
11.00	CLINIC							11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2023 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm	
			RHC IV	Cost	
			1.00		
1.00	1.00	Clinic Address and Identification Street		2 S. PEARL STREET	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	2.00	City, State, ZIP Code, County		KNOX IN 46534	
			1.00		
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
			Grant Award		Date
			1.00		2.00
4.00	4.00	Source of Federal Funds			
5.00	5.00	Community Health Center (Section 330(d), PHS Act)			
6.00	6.00	Migrant Health Center (Section 329(d), PHS Act)			
7.00	7.00	Health Services for the Homeless (Section 340(d), PHS Act)			
8.00	8.00	Appalachian Regional Commission			
9.00	9.00	Look-Alikes			
9.00	9.00	OTHER (SPECIFY)			
			1.00		2.00
10.00	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
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	11.00	Facility hours of operations (1)			
11.00	11.00	CLINIC			08:00 19:00 08:00
		1.00		2.00	3.00
12.00	12.00	Have you received an approval for an exception to the productivity standard?			N
13.00	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
			Provider name		CCN
			1.00		2.00
14.00	14.00	RHC/FQHC name, CCN			
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			
		County			
		4.00			
2.00	2.00	City, State, ZIP Code, County			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8554

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

Worksheet S-8
Date/Time Prepared:
2/25/2025 3:44 pm

		Tuesday		Wednesday		Thursday		RHC IV	Cost
		to	from	to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00			
11.00	Facility hours of operations (1) CLINIC	19:00	08:00	19:00	08:00	19:00	11.00		
		Friday		Saturday					
		from	to	from	to				
		11.00	12.00	13.00	14.00				
11.00	Facility hours of operations (1) CLINIC	08:00	16:00	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8581	Period: From 10/01/2023 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 pm	
			RHC V	Cost	
			1.00		
1.00	Clinic Address and Identification Street		232 S. MAIN STREET SUITE A		1.00
		City	State	ZIP Code	
2.00	City, State, ZIP Code, County		CULVER	IN	46511
			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	
4.00	Source of Federal Funds 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
		Sunday	Monday	Tuesday	
		from to	from to	from	
		1.00 2.00	3.00 4.00	5.00	
11.00	Facility hours of operations (1) CLINIC		08:30	16:30	08:30
			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
			Provider name	CCN	
			1.00	2.00	
14.00	RHC/FQHC name, CCN				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County		MARSHALL		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1305 Component CCN: 15-8581		Period: From 10/01/2023 To 09/30/2024		Worksheet S-8 Date/Time Prepared: 2/25/2025 3:44 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	17:00	08:30	18:00	08:30	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	08:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 2/25/2025 3:44 pm
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			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)		0.440133	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,783,516	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		589,577	5.00
6.00	Medicaid charges		9,347,542	6.00
7.00	Medicaid cost (line 1 times line 6)		4,114,162	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		1,741,069	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)		1,741,069	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)	34,095	234,910	269,005
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,006	234,910	249,916
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	15,006	234,910	249,916
			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)		1,978,330	26.00
27.00	Medicare reimbursable bad debts (see instructions)		101,961	27.00
27.01	Medicare allowable bad debts (see instructions)		156,863	27.01
28.00	Non-Medicare bad debt amount (see instructions)		1,821,467	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		856,590	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		1,106,506	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,847,575	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 2/25/2025 3:44 pm
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			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	Total (col. 1 + col. 2)
		1.00	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: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,085,699	2,085,699	80,690	2,166,389	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,670,407	5,670,407	0	5,670,407	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,837,980	4,159,837	6,997,817	332,540	7,330,357	5.00
7.00	00700	OPERATION OF PLANT	384,054	736,805	1,120,859	584,120	1,704,979	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,582	78,849	86,431	0	86,431	8.00
9.00	00900	HOUSEKEEPING	231,559	135,432	366,991	0	366,991	9.00
10.00	01000	DIETARY	259,685	220,295	479,980	-754	479,226	10.00
13.00	01300	NURSING ADMINISTRATION	453,406	38,229	491,635	0	491,635	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,178	48,279	101,457	0	101,457	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,494	42,136	325,630	-30,757	294,873	16.00
17.00	01700	SOCIAL SERVICE	55,410	165	55,575	0	55,575	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,841,911	67,953	1,909,864	173,318	2,083,182	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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	696,651	123,269	819,920	1,095,725	1,915,645	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	606,230	606,230	0	606,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,915	627,666	1,741,581	-295,562	1,446,019	54.00
60.00	06000	LABORATORY	853,594	732,947	1,586,541	-52,287	1,534,254	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	37,693	37,693	0	37,693	63.00
65.00	06500	RESPIRATORY THERAPY	406,669	38,536	445,205	0	445,205	65.00
66.00	06600	PHYSICAL THERAPY	972,962	11,668	984,630	0	984,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	199,748	1,051	200,799	0	200,799	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	352	7,499	7,851	0	7,851	69.00
69.01	06901	CARDIAC REHABILITATION	62,622	4,262	66,884	0	66,884	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	710,055	710,055	-130,231	579,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,231	130,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,650	5,193,663	5,262,313	-1,852	5,260,461	73.00
76.00	03020	ONCOLOGY	136,534	127,767	264,301	0	264,301	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,908,196	654,896	6,563,092	-2,331,705	4,231,387	88.00
88.01	08801	RURAL HEALTH CLINIC II	557,927	120,095	678,022	242,511	920,533	88.01
88.02	08802	RURAL HEALTH CLINIC III	540	15,508	16,048	140,261	156,309	88.02
88.03	08803	RURAL HEALTH CLINIC IV	529,153	100,068	629,221	44,193	673,414	88.03
88.04	08804	RURAL HEALTH CLINIC V	184,422	95,040	279,462	-53,616	225,846	88.04
90.00	09000	CLINIC	27,503	28,587	56,090	0	56,090	90.00
90.01	09001	WOUND CARE	138,195	401,426	539,621	194,952	734,573	90.01
91.00	09100	EMERGENCY	1,255,259	1,582,882	2,838,141	-801	2,837,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,521,151	24,504,894	44,026,045	120,976	44,147,021	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	312,925	84,506	397,431	-26,505	370,926	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	0	0	0	150,838	150,838	192.03
194.00	07950	MARKETING	112,766	175,266	288,032	-245,309	42,723	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,946,842	24,764,666	44,711,508	0	44,711,508	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1305

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

Worksheet A
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-20,880	2,145,509	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5,670,407	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-882,387	6,447,970	5.00
7.00	00700 OPERATION OF PLANT	-278	1,704,701	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	86,431	8.00
9.00	00900 HOUSEKEEPING	0	366,991	9.00
10.00	01000 DIETARY	-67,279	411,947	10.00
13.00	01300 NURSING ADMINISTRATION	0	491,635	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-36,303	65,154	14.00
15.00	01500 PHARMACY	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-7,897	286,976	16.00
17.00	01700 SOCIAL SERVICE	0	55,575	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-495,071	1,588,111	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
43.00	04300 NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1,140,874	774,771	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	-600,000	6,230	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,446,019	54.00
60.00	06000 LABORATORY	0	1,534,254	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	37,693	63.00
65.00	06500 RESPIRATORY THERAPY	0	445,205	65.00
66.00	06600 PHYSICAL THERAPY	0	984,630	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	200,799	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	-2,385	5,466	69.00
69.01	06901 CARDIAC REHABILITATION	0	66,884	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	579,824	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	130,231	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-2,721,578	2,538,883	73.00
76.00	03020 ONCOLOGY	-97,951	166,350	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	4,231,387	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	920,533	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	156,309	88.02
88.03	08803 RURAL HEALTH CLINIC IV	-11,729	661,685	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	225,846	88.04
90.00	09000 CLINIC	26,150	82,240	90.00
90.01	09001 WOUND CARE	-384,921	349,652	90.01
91.00	09100 EMERGENCY	0	2,837,340	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-6,443,383	37,703,638	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001 HOMECARE	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	-11,729	359,197	192.00
192.01	19201 KNOX RHC	0	0	192.01
192.02	19202 RETAIL PHARMACY	0	0	192.02
192.03	19203 CULVER	0	150,838	192.03
194.00	07950 MARKETING	0	42,723	194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-6,455,112	38,256,396	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - PROPERTY INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	80,690	1.00	
	O		0	80,690		
B - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	96,040	149,269	1.00	
	O		96,040	149,269		
C - IMPLANTABLE DEVICE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	130,231	1.00	
	O		0	130,231		
D - PHYSICIAN SALARIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	175,069	0	1.00	
2.00	OPERATING ROOM	50.00	1,129,990	0	2.00	
3.00	RURAL HEALTH CLINIC	88.00	38,595	0	3.00	
4.00	RURAL HEALTH CLINIC II	88.01	345,216	0	4.00	
5.00	RURAL HEALTH CLINIC III	88.02	129,077	0	5.00	
6.00	RURAL HEALTH CLINIC IV	88.03	20,358	0	6.00	
7.00	RURAL HEALTH CLINIC V	88.04	90,865	0	7.00	
8.00	WOUND CARE	90.01	194,952	0	8.00	
	O		2,124,122	0		
E - PATIENT ACCOUNTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	201,848	1.00	
	O		0	201,848		
F - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	0	21,052	1.00	
2.00	RURAL HEALTH CLINIC III	88.02	0	11,184	2.00	
3.00	RURAL HEALTH CLINIC IV	88.03	0	26,650	3.00	
4.00	RURAL HEALTH CLINIC V	88.04	0	6,357	4.00	
	O		0	65,243		
H - MAINTENANCE RECLASS						
1.00	OPERATION OF PLANT	7.00	0	584,120	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
	O		0	584,120		
I - CULVER RECLASS						
1.00	CULVER	192.03	107,580	43,258	1.00	
	TOTALS		107,580	43,258		
500.00	Grand Total: Increases		2,327,742	1,254,659	500.00	

RECLASSIFICATIONS

Provider CCN: 15-1305

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

Worksheet A-6

Date/Time Prepared:
2/25/2025 3:44 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,690	12	1.00
	O		0	80,690		
B - MARKETING RECLASS						
1.00	MARKETING	194.00	96,040	149,269	0	1.00
	O		96,040	149,269		
C - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	130,231	0	1.00
	O		0	130,231		
D - PHYSICIAN SALARIES RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	1,974,365	0	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	123,757	0	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	26,000	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
	O		2,124,122	0		
E - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	201,848	0	1.00
	O		0	201,848		
F - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	65,243	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
	O		0	65,243		
H - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,927	0	1.00
2.00	DIETARY	10.00	0	754	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	30,757	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,751	0	4.00
5.00	OPERATING ROOM	50.00	0	34,265	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	295,562	0	6.00
7.00	LABORATORY	60.00	0	52,287	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,852	0	8.00
9.00	RURAL HEALTH CLINIC	88.00	0	128,844	0	9.00
10.00	RURAL HEALTH CLINIC IV	88.03	0	2,815	0	10.00
11.00	EMERGENCY	91.00	0	801	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	505	0	12.00
	O		0	584,120		
I - CULVER RECLASS						
1.00	RURAL HEALTH CLINIC V	88.04	107,580	43,258	0	1.00
	TOTALS		107,580	43,258		
500.00	Grand Total: Decreases		2,327,742	1,254,659		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

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

Worksheet A-7
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	236,907	65,755	0	65,755	0	1.00
2.00	Land Improvements	432,594	128	0	128	0	2.00
3.00	Buildings and Fixtures	13,253,038	9,120	0	9,120	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	7,732,825	245,472	0	245,472	0	5.00
6.00	Movable Equipment	17,613,376	1,373,033	0	1,373,033	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,455,795	1,693,508	0	1,693,508	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,455,795	1,693,508	0	1,693,508	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	302,662	0				1.00
2.00	Land Improvements	432,722	0				2.00
3.00	Buildings and Fixtures	13,262,158	0				3.00
4.00	Building Improvements	187,055	0				4.00
5.00	Fixed Equipment	7,978,297	0				5.00
6.00	Movable Equipment	18,986,409	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	41,149,303	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	41,149,303	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

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

Worksheet A-7
Part II
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	SUMMARY OF CAPITAL					
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,486,424	0	599,275	0	0	1.00
3.00	Total (sum of lines 1-2)	1,486,424	0	599,275	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,085,699	1.00
3.00	Total (sum of lines 1-2)	0	2,085,699	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

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

Worksheet A-7
Part III
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	41,149,303	0	41,149,303	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	41,149,303	0	41,149,303	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,485,691	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,485,691	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	579,128	80,690	0	0	2,145,509	1.00
3.00	Total (sum of lines 1-2)	579,128	80,690	0	0	2,145,509	3.00

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.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,095,052			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests			0	0.00	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts			0	0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1305

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

Worksheet A-8

Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 INVEST INC/UNRESTRICTED- INT EXP	B	-20,147		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01 OTHER SERVICES -OTHER REV	B	-7,582		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 CAFETERIA VENDING - OTHER REV	B	-67,279		DIETARY	10.00	0	33.02
33.03 REBATES & REFUNDS - OTHER REV	B	-36,303		CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04 MEDICAL RECORDS FEES -OTHER REV	B	-7,897		MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05 EMPLOYEE RX PROGRAM -OTHER REV	B	-8,900		DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.08 TELEVISION	A	-278		OPERATION OF PLANT	7.00	0	33.08
33.09 PHYSICIAN RECRUITMENT- ADMIN	A	-44,558		ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 LOBBYING EXPENSE	A	-4,233		ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 CRNA	A	-600,000		ANESTHESIOLOGY	53.00	0	33.11
33.12 HAF EXPENSE	A	-826,014		ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 EHR DEPRECIATION ON 2012 PAYMENT	A	-733		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14 RENTAL INCOME - KNOX	B	-11,729		RURAL HEALTH CLINIC IV	88.03	0	33.14
33.15 RENTAL INCOME - PHYSICIAN	B	-11,729		PHYSICIANS' PRIVATE OFFICES	192.00	0	33.15
33.16 RETAIL PHARMACY INCOME	B	-2,712,678		DRUGS CHARGED TO PATIENTS	73.00	0	33.16
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,455,112					50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1305

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2025 3:44 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	495,071	495,071	0	0	0	1.00
2.00	50.00	OPERATING ROOM	1,140,874	1,140,874	0	0	0	2.00
3.00	60.00	LABORATORY	11,303	0	11,303	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	2,385	2,385	0	0	0	4.00
5.00	76.00	ONCOLOGY	97,951	97,951	0	0	0	5.00
6.00	90.00	CLINIC	-26,150	-26,150	0	0	0	6.00
7.00	90.01	WOUND CARE	384,921	384,921	0	0	0	7.00
8.00	91.00	EMERGENCY	1,446,288	0	1,446,288	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			3,552,643	2,095,052	1,457,591	0	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	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.00	ONCOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	495,071		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,140,874		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,385		4.00
5.00	76.00	ONCOLOGY	0	0	0	97,951		5.00
6.00	90.00	CLINIC	0	0	0	-26,150		6.00
7.00	90.01	WOUND CARE	0	0	0	384,921		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,095,052		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,145,509	2,145,509				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,670,407	25,834	5,696,241			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,447,970	423,065	837,871	7,708,906	7,708,906	5.00
7.00 00700	OPERATION OF PLANT	1,704,701	187,635	109,675	2,002,011	505,223	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	86,431	18,445	2,165	107,041	27,013	8.00
9.00 00900	HOUSEKEEPING	366,991	11,502	66,127	444,620	112,203	9.00
10.00 01000	DIETARY	411,947	90,286	74,159	576,392	145,457	10.00
13.00 01300	NURSING ADMINISTRATION	491,635	13,319	129,480	634,434	160,104	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	65,154	28,159	15,186	108,499	27,381	14.00
15.00 01500	PHARMACY	0	23,093	0	23,093	5,828	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	286,976	45,978	80,958	413,912	104,454	16.00
17.00 01700	SOCIAL SERVICE	55,575	0	15,823	71,398	18,018	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,588,111	265,376	575,991	2,429,478	613,098	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
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	774,771	163,231	521,636	1,459,638	368,351	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	6,230	924	0	7,154	1,805	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,446,019	143,415	318,102	1,907,536	481,382	54.00
60.00 06000	LABORATORY	1,534,254	46,007	243,762	1,824,023	460,307	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	37,693	1,818	0	39,511	9,971	63.00
65.00 06500	RESPIRATORY THERAPY	445,205	23,331	116,133	584,669	147,546	65.00
66.00 06600	PHYSICAL THERAPY	984,630	52,712	277,850	1,315,192	331,899	66.00
67.00 06700	OCCUPATIONAL THERAPY	200,799	0	57,042	257,841	65,068	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	5,466	0	101	5,567	1,405	69.00
69.01 06901	CARDIAC REHABILITATION	66,884	13,349	17,883	98,116	24,760	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	579,824	0	0	579,824	146,323	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	130,231	0	0	130,231	32,865	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,538,883	0	19,604	2,558,487	645,655	73.00
76.00 03020	ONCOLOGY	166,350	30,334	38,990	235,674	59,474	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	4,231,387	239,363	1,134,410	5,605,160	1,414,510	88.00
88.01 08801	RURAL HEALTH CLINIC II	920,533	0	222,570	1,143,103	288,471	88.01
88.02 08802	RURAL HEALTH CLINIC III	156,309	0	37,015	193,324	48,787	88.02
88.03 08803	RURAL HEALTH CLINIC IV	661,685	0	156,924	818,609	206,583	88.03
88.04 08804	RURAL HEALTH CLINIC V	225,846	0	47,892	273,738	69,080	88.04
90.00 09000	CLINIC	82,240	27,056	7,854	117,150	29,564	90.00
90.01 09001	WOUND CARE	349,652	65,763	95,137	510,552	128,842	90.01
91.00 09100	EMERGENCY	2,837,340	192,075	358,466	3,387,881	854,959	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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							
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	37,703,638	2,132,070	5,578,806	37,572,764	7,536,386	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,439	0	13,439	3,391	190.00
190.01 19001	HOMECARE	0	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	359,197	0	81,937	441,134	111,324	192.00
192.01 19201	KNOX RHC	0	0	0	0	0	192.01
192.02 19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03 19203	CULVER	150,838	0	30,722	181,560	45,818	192.03
194.00 07950	MARKETING	42,723	0	4,776	47,499	11,987	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	38,256,396	2,145,509	5,696,241	38,256,396	7,708,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		7.00	8.00	9.00	10.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,507,234				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	23,787	157,841			8.00	
9.00	00900	HOUSEKEEPING	14,833	0	571,656		9.00	
10.00	01000	DIETARY	116,439	0	27,854	866,142	10.00	
13.00	01300	NURSING ADMINISTRATION	17,178	0	4,109	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	36,315	0	8,687	0	14.00	
15.00	01500	PHARMACY	29,782	0	7,124	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	59,295	0	14,184	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	342,244	27,580	81,873	866,142	440,814	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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	210,512	38,042	50,358	0	112,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,191	0	285	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,957	30,610	44,244	0	0	54.00
60.00	06000	LABORATORY	59,334	288	14,193	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,344	0	561	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	30,090	0	7,198	0	21,109	65.00
66.00	06600	PHYSICAL THERAPY	90,845	23,903	21,731	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	17,216	0	4,118	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	ONCOLOGY	39,120	0	9,358	0	43,431	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	308,697	1,807	73,845	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	150,025	319	35,888	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	63,100	146	15,094	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	82,660	30	19,773	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	114	0	0	0	88.04
90.00	09000	CLINIC	34,893	0	8,347	0	12,838	90.00
90.01	09001	WOUND CARE	84,812	6,206	20,288	0	0	90.01
91.00	09100	EMERGENCY	247,711	28,750	59,256	0	184,775	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								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,247,380	157,795	528,368	866,142	815,825	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,331	0	4,146	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	242,523	46	39,142	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	0	0	0	0	0	192.03
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,507,234	157,841	571,656	866,142	815,825	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	180,882				14.00
15.00	01500	PHARMACY	0	65,827			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	591,845		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	89,416	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	13,829	83,448	4,898,506
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	48,238	5,968	2,293,965
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	6,145	0	16,580
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	155,420	0	2,804,149
60.00	06000	LABORATORY	0	0	114,248	0	2,472,393
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,788	0	54,175
65.00	06500	RESPIRATORY THERAPY	0	0	8,103	0	798,715
66.00	06600	PHYSICAL THERAPY	0	0	23,723	0	1,807,293
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,630	0	328,539
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	4,704	0	11,676
69.01	06901	CARDIAC REHABILITATION	0	0	2,462	0	146,672
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,660	0	20,861	0	911,668
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,222	0	2,361	0	181,679
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,827	69,268	0	3,339,237
76.00	03020	ONCOLOGY	0	0	3,531	0	390,588
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	41,102	0	7,445,121
88.01	08801	RURAL HEALTH CLINIC II	0	0	3,886	0	1,621,692
88.02	08802	RURAL HEALTH CLINIC III	0	0	44	0	320,495
88.03	08803	RURAL HEALTH CLINIC IV	0	0	3,838	0	1,131,493
88.04	08804	RURAL HEALTH CLINIC V	0	0	1,102	0	344,034
90.00	09000	CLINIC	0	0	90	0	202,882
90.01	09001	WOUND CARE	0	0	13,691	0	764,391
91.00	09100	EMERGENCY	0	0	47,781	0	4,811,113
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	180,882	65,827	591,845	89,416	37,097,056
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	38,307
190.01	19001	HOMECARE	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	834,169
192.01	19201	KNOX RHC	0	0	0	0	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	CULVER	0	0	0	0	227,378
194.00	07950	MARKETING	0	0	0	0	59,486
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	180,882	65,827	591,845	89,416	38,256,396

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
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
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,898,506	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,293,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	16,580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,804,149	54.00
60.00	06000	LABORATORY	2,472,393	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	54,175	63.00
65.00	06500	RESPIRATORY THERAPY	798,715	65.00
66.00	06600	PHYSICAL THERAPY	1,807,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,539	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,676	69.00
69.01	06901	CARDIAC REHABILITATION	146,672	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	911,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339,237	73.00
76.00	03020	ONCOLOGY	390,588	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	7,445,121	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,621,692	88.01
88.02	08802	RURAL HEALTH CLINIC III	320,495	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,131,493	88.03
88.04	08804	RURAL HEALTH CLINIC V	344,034	88.04
90.00	09000	CLINIC	202,882	90.00
90.01	09001	WOUND CARE	764,391	90.01
91.00	09100	EMERGENCY	4,811,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,097,056	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,307	190.00
190.01	19001	HOMECARE	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	834,169	192.00
192.01	19201	KNOX RHC	0	192.01
192.02	19202	RETAIL PHARMACY	0	192.02
192.03	19203	CULVER	227,378	192.03
194.00	07950	MARKETING	59,486	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,256,396	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1305

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
		0	1.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,834	25,834	25,834		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	423,065	423,065	3,800	426,865	5.00
7.00 00700	OPERATION OF PLANT	0	187,635	187,635	497	27,976	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,445	18,445	10	1,496	8.00
9.00 00900	HOUSEKEEPING	0	11,502	11,502	300	6,213	9.00
10.00 01000	DIETARY	0	90,286	90,286	336	8,055	10.00
13.00 01300	NURSING ADMINISTRATION	0	13,319	13,319	587	8,866	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	28,159	28,159	69	1,516	14.00
15.00 01500	PHARMACY	0	23,093	23,093	0	323	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	45,978	45,978	367	5,784	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	72	998	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	265,376	265,376	2,612	33,950	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
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	163,231	163,231	2,366	20,397	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	924	924	0	100	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	143,415	143,415	1,443	26,656	54.00
60.00 06000	LABORATORY	0	46,007	46,007	1,105	25,489	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	1,818	1,818	0	552	63.00
65.00 06500	RESPIRATORY THERAPY	0	23,331	23,331	527	8,170	65.00
66.00 06600	PHYSICAL THERAPY	0	52,712	52,712	1,260	18,378	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	259	3,603	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	78	69.00
69.01 06901	CARDIAC REHABILITATION	0	13,349	13,349	81	1,371	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,102	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,820	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	89	35,752	73.00
76.00 03020	ONCOLOGY	0	30,334	30,334	177	3,293	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	239,363	239,363	5,145	78,321	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	1,009	15,974	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	0	0	168	2,702	88.02
88.03 08803	RURAL HEALTH CLINIC IV	0	0	0	712	11,439	88.03
88.04 08804	RURAL HEALTH CLINIC V	0	0	0	217	3,825	88.04
90.00 09000	CLINIC	0	27,056	27,056	36	1,637	90.00
90.01 09001	WOUND CARE	0	65,763	65,763	431	7,134	90.01
91.00 09100	EMERGENCY	0	192,075	192,075	1,626	47,342	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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							
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,132,070	2,132,070	25,301	417,312	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,439	13,439	0	188	190.00
190.01 19001	HOME CARE	0	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	372	6,164	192.00
192.01 19201	KNOX RHC	0	0	0	0	0	192.01
192.02 19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03 19203	CULVER	0	0	0	139	2,537	192.03
194.00 07950	MARKETING	0	0	0	22	664	194.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,145,509	2,145,509	25,834	426,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet B Part II Date/Time Prepared: 2/25/2025 3:44 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATIVE		
		7.00	8.00	9.00	10.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	216,108				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,050	22,001			8.00	
9.00	00900	HOUSEKEEPING	1,279	0	19,294		9.00	
10.00	01000	DIETARY	10,036	0	940	109,653	10.00	
13.00	01300	NURSING ADMINISTRATION	1,481	0	139	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	3,130	0	293	0	14.00	
15.00	01500	PHARMACY	2,567	0	240	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	5,111	0	479	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,498	3,844	2,764	109,653	13,179	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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,145	5,304	1,700	0	3,374	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	103	0	10	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,942	4,267	1,493	0	0	54.00
60.00	06000	LABORATORY	5,114	40	479	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	202	0	19	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,594	0	243	0	631	65.00
66.00	06600	PHYSICAL THERAPY	7,830	3,332	733	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,484	0	139	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	ONCOLOGY	3,372	0	316	0	1,299	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	26,608	252	2,492	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,931	44	1,211	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,439	20	509	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	7,125	4	667	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	16	0	0	0	88.04
90.00	09000	CLINIC	3,008	0	282	0	384	90.00
90.01	09001	WOUND CARE	7,310	865	685	0	0	90.01
91.00	09100	EMERGENCY	21,351	4,007	2,000	0	5,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,710	21,995	17,833	109,653	24,392	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,494	0	140	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,904	6	1,321	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	CULVER	0	0	0	0	0	192.03
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	216,108	22,001	19,294	109,653	24,392	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet B Part II Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,167				14.00
15.00	01500	PHARMACY	0	26,223			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	57,719		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,070	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,349	999	463,224
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	4,706	71	219,294
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	599	0	1,736
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	15,148	0	208,364
60.00	06000	LABORATORY	0	0	11,145	0	89,379
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	174	0	2,765
65.00	06500	RESPIRATORY THERAPY	0	0	790	0	36,286
66.00	06600	PHYSICAL THERAPY	0	0	2,314	0	86,559
67.00	06700	OCCUPATIONAL THERAPY	0	0	549	0	4,411
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	459	0	537
69.01	06901	CARDIAC REHABILITATION	0	0	240	0	16,664
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,192	0	2,035	0	40,329
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,975	0	230	0	5,025
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,223	6,757	0	68,821
76.00	03020	ONCOLOGY	0	0	344	0	39,135
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	4,010	0	356,191
88.01	08801	RURAL HEALTH CLINIC II	0	0	379	0	31,548
88.02	08802	RURAL HEALTH CLINIC III	0	0	4	0	8,842
88.03	08803	RURAL HEALTH CLINIC IV	0	0	374	0	20,321
88.04	08804	RURAL HEALTH CLINIC V	0	0	107	0	4,165
90.00	09000	CLINIC	0	0	9	0	32,412
90.01	09001	WOUND CARE	0	0	1,336	0	83,524
91.00	09100	EMERGENCY	0	0	4,661	0	278,587
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
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,167	26,223	57,719	1,070	2,098,119
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,261
190.01	19001	HOMECARE	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	28,767
192.01	19201	KNOX RHC	0	0	0	0	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	CULVER	0	0	0	0	2,676
194.00	07950	MARKETING	0	0	0	0	686
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	33,167	26,223	57,719	1,070	2,145,509

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1305

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
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
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	463,224	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	219,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	1,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	208,364	54.00
60.00	06000	LABORATORY	89,379	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,765	63.00
65.00	06500	RESPIRATORY THERAPY	36,286	65.00
66.00	06600	PHYSICAL THERAPY	86,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,411	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	537	69.00
69.01	06901	CARDIAC REHABILITATION	16,664	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,821	73.00
76.00	03020	ONCOLOGY	39,135	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	356,191	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,548	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,842	88.02
88.03	08803	RURAL HEALTH CLINIC IV	20,321	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,165	88.04
90.00	09000	CLINIC	32,412	90.00
90.01	09001	WOUND CARE	83,524	90.01
91.00	09100	EMERGENCY	278,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,098,119	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,261	190.00
190.01	19001	HOMECARE	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,767	192.00
192.01	19201	KNOX RHC	0	192.01
192.02	19202	RETAIL PHARMACY	0	192.02
192.03	19203	CULVER	2,076	192.03
194.00	07950	MARKETING	686	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,145,509	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

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

Worksheet B-1
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci liatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	72,003				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	867	19,946,842			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,198	2,934,020	-7,708,906	30,547,490	5.00
7.00 00700	OPERATION OF PLANT	6,297	384,054	0	2,002,011	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	619	7,582	0	107,041	8.00
9.00 00900	HOUSEKEEPING	386	231,559	0	444,620	9.00
10.00 01000	DIETARY	3,030	259,685	0	576,392	10.00
13.00 01300	NURSING ADMINISTRATION	447	453,406	0	634,434	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	945	53,178	0	108,499	14.00
15.00 01500	PHARMACY	775	0	0	23,093	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,543	283,494	0	413,912	16.00
17.00 01700	SOCIAL SERVICE	0	55,410	0	71,398	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,906	2,016,980	0	2,429,478	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,478	1,826,641	0	1,459,638	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	31	0	0	7,154	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,813	1,113,915	0	1,907,536	54.00
60.00 06000	LABORATORY	1,544	853,594	0	1,824,023	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	61	0	0	39,511	63.00
65.00 06500	RESPIRATORY THERAPY	783	406,669	0	584,669	65.00
66.00 06600	PHYSICAL THERAPY	1,769	972,962	0	1,315,192	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	199,748	0	257,841	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	352	0	5,567	69.00
69.01 06901	CARDIAC REHABILITATION	448	62,622	0	98,116	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	579,824	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,231	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	68,650	0	2,558,487	73.00
76.00 03020	ONCOLOGY	1,018	136,534	0	235,674	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	8,033	3,972,426	0	5,605,160	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	779,386	0	1,143,103	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	129,617	0	193,324	88.02
88.03 08803	RURAL HEALTH CLINIC IV	0	549,511	0	818,609	88.03
88.04 08804	RURAL HEALTH CLINIC V	0	167,707	0	273,738	88.04
90.00 09000	CLINIC	908	27,503	0	117,150	90.00
90.01 09001	WOUND CARE	2,207	333,147	0	510,552	90.01
91.00 09100	EMERGENCY	6,446	1,255,259	0	3,387,881	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						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	71,552	19,535,611	-7,708,906	29,863,858	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	13,439	190.00
190.01 19001	HOMECARE	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	286,925	0	441,134	192.00
192.01 19201	KNOX RHC	0	0	0	0	192.01
192.02 19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03 19203	CULVER	0	107,580	0	181,560	192.03
194.00 07950	MARKETING	0	16,726	0	47,499	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,145,509	5,696,241		7,708,906	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.797495	0.285571		0.252358	38.428576
204.00	Cost to be allocated (per Wkst. B, Part II)		25,834		426,865	216,108
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001295		0.013974	3.312305

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

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

Worksheet B-1
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci liatio n	ADMI NI STRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
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: 15-1305

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

Worksheet B-1

Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	104,023					8.00
9.00	00900	0	62,186				9.00
10.00	01000	0	3,030	100			10.00
13.00	01300	0	447	0	51,093		13.00
14.00	01400	0	945	0	0	3,749,580	14.00
15.00	01500	0	775	0	0	0	15.00
16.00	01600	0	1,543	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,176	8,906	100	27,607	0	30.00
31.00	03100	0	0	0	0	0	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,072	5,478	0	7,068	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	31	0	0	0	53.00
54.00	05400	20,173	4,813	0	0	0	54.00
60.00	06000	190	1,544	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	61	0	0	0	63.00
65.00	06500	0	783	0	1,322	0	65.00
66.00	06600	15,753	2,364	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	06901	0	448	0	0	0	69.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	3,413,301	71.00
72.00	07200	0	0	0	0	336,279	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	1,018	0	2,720	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,191	8,033	0	0	0	88.00
88.01	08801	210	3,904	0	0	0	88.01
88.02	08802	96	1,642	0	0	0	88.02
88.03	08803	20	2,151	0	0	0	88.03
88.04	08804	75	0	0	0	0	88.04
90.00	09000	0	908	0	804	0	90.00
90.01	09001	4,090	2,207	0	0	0	90.01
91.00	09100	18,947	6,446	0	11,572	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		103,993	57,477	100	51,093	3,749,580	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	451	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	30	4,258	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		157,841	571,656	866,142	815,825	180,882	202.00
203.00		1.517366	9.192680	8,661.420000	15.967452	0.048241	203.00
204.00		22,001	19,294	109,653	24,392	33,167	204.00
205.00		0.211501	0.310263	1,096.530000	0.477404	0.008846	205.00
206.00							206.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1305			Period: From 10/01/2023 To 09/30/2024		Worksheet B-1 Date/Time Prepared: 2/25/2025 3:44 pm	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	8.00	9.00	10.00	13.00	14.00	207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

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

Worksheet B-1
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	100			15.00
16.00	01600	0	84,285,950		16.00
17.00	01700	0	0	9,888	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	1,969,439	9,228	30.00
31.00	03100	0	0	0	31.00
43.00	04300	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	6,869,529	660	50.00
52.00	05200	0	0	0	52.00
53.00	05300	0	875,120	0	53.00
54.00	05400	0	22,134,995	0	54.00
60.00	06000	0	16,269,992	0	60.00
60.01	06001	0	0	0	60.01
63.00	06300	0	254,637	0	63.00
65.00	06500	0	1,154,010	0	65.00
66.00	06600	0	3,378,340	0	66.00
67.00	06700	0	801,742	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	0	669,840	0	69.00
69.01	06901	0	350,583	0	69.01
70.00	07000	0	0	0	70.00
71.00	07100	0	2,970,834	0	71.00
72.00	07200	0	336,279	0	72.00
73.00	07300	100	9,864,391	0	73.00
76.00	03020	0	502,842	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	5,853,355	0	88.00
88.01	08801	0	553,419	0	88.01
88.02	08802	0	6,197	0	88.02
88.03	08803	0	546,537	0	88.03
88.04	08804	0	156,878	0	88.04
90.00	09000	0	12,772	0	90.00
90.01	09001	0	1,949,716	0	90.01
91.00	09100	0	6,804,503	0	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	0	0	0	116.00
118.00		100	84,285,950	9,888	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
192.02	19202	0	0	0	192.02
192.03	19203	0	0	0	192.03
194.00	07950	0	0	0	194.00
200.00					200.00
201.00					201.00
202.00		65,827	591,845	89,416	202.00
203.00		658.270000	0.007022	9.042880	203.00
204.00		26,223	57,719	1,070	204.00
205.00		262.230000	0.000685	0.108212	205.00
206.00					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1305

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

Worksheet B-1
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	15.00	16.00	17.00	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2025 3:44 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	4,898,506		4,898,506	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0 31.00
43.00	04300 NURSERY	0		0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,293,965		2,293,965	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	16,580		16,580	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,804,149		2,804,149	0	0 54.00
60.00	06000 LABORATORY	2,472,393		2,472,393	0	0 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	54,175		54,175	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	798,715	0	798,715	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,807,293	0	1,807,293	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	328,539	0	328,539	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	11,676		11,676	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	146,672		146,672	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	911,668		911,668	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	181,679		181,679	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,339,237		3,339,237	0	0 73.00
76.00	03020 ONCOLOGY	390,588		390,588	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	7,445,121		7,445,121	0	0 88.00
88.01	08801 RURAL HEALTH CLINIC II	1,621,692		1,621,692	0	0 88.01
88.02	08802 RURAL HEALTH CLINIC III	320,495		320,495	0	0 88.02
88.03	08803 RURAL HEALTH CLINIC IV	1,131,493		1,131,493	0	0 88.03
88.04	08804 RURAL HEALTH CLINIC V	344,034		344,034	0	0 88.04
90.00	09000 CLINIC	202,882		202,882	0	0 90.00
90.01	09001 WOUND CARE	764,391		764,391	0	0 90.01
91.00	09100 EMERGENCY	4,811,113		4,811,113	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,595,792		1,595,792	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	0		0		0 116.00
200.00	Subtotal (see instructions)	38,692,848	0	38,692,848	0	0 200.00
201.00	Less Observation Beds	1,595,792		1,595,792		0 201.00
202.00	Total (see instructions)	37,097,056	0	37,097,056	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,106,094		1,106,094		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	445,257	6,424,272	6,869,529	0.333933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	31,264	843,856	875,120	0.018946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,232,414	20,902,581	22,134,995	0.126684	54.00
60.00	06000	LABORATORY	1,706,983	14,563,009	16,269,992	0.151960	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	40,883	213,754	254,637	0.212754	63.00
65.00	06500	RESPIRATORY THERAPY	537,431	616,579	1,154,010	0.692121	65.00
66.00	06600	PHYSICAL THERAPY	379,675	2,998,665	3,378,340	0.534965	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,836	593,906	801,742	0.409781	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,600	653,240	669,840	0.017431	69.00
69.01	06901	CARDIAC REHABILITATION	0	350,583	350,583	0.418366	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,013,582	1,957,252	2,970,834	0.306873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,343	263,936	336,279	0.540263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,024,360	4,840,031	9,864,391	0.338514	73.00
76.00	03020	ONCOLOGY	4,784	498,058	502,842	0.776761	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,853,355	5,853,355		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	553,419	553,419		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	6,197	6,197		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	546,537	546,537		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	156,878	156,878		88.04
90.00	09000	CLINIC	0	12,772	12,772	15.884904	90.00
90.01	09001	WOUND CARE	6,067	1,943,649	1,949,716	0.392052	90.01
91.00	09100	EMERGENCY	229,339	6,575,164	6,804,503	0.707048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	861,345	863,345	1.848383	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	12,056,912	72,229,038	84,285,950		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,056,912	72,229,038	84,285,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
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					
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: 15-1305

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,898,506		4,898,506	0	4,898,506 30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0 31.00
43.00	04300 NURSERY	0		0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,293,965		2,293,965	0	2,293,965 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	16,580		16,580	0	16,580 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,804,149		2,804,149	0	2,804,149 54.00
60.00	06000 LABORATORY	2,472,393		2,472,393	0	2,472,393 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	54,175		54,175	0	54,175 63.00
65.00	06500 RESPIRATORY THERAPY	798,715	0	798,715	0	798,715 65.00
66.00	06600 PHYSICAL THERAPY	1,807,293	0	1,807,293	0	1,807,293 66.00
67.00	06700 OCCUPATIONAL THERAPY	328,539	0	328,539	0	328,539 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	11,676		11,676	0	11,676 69.00
69.01	06901 CARDIAC REHABILITATION	146,672		146,672	0	146,672 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	911,668		911,668	0	911,668 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	181,679		181,679	0	181,679 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,339,237		3,339,237	0	3,339,237 73.00
76.00	03020 ONCOLOGY	390,588		390,588	0	390,588 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	7,445,121		7,445,121	0	7,445,121 88.00
88.01	08801 RURAL HEALTH CLINIC II	1,621,692		1,621,692	0	1,621,692 88.01
88.02	08802 RURAL HEALTH CLINIC III	320,495		320,495	0	320,495 88.02
88.03	08803 RURAL HEALTH CLINIC IV	1,131,493		1,131,493	0	1,131,493 88.03
88.04	08804 RURAL HEALTH CLINIC V	344,034		344,034	0	344,034 88.04
90.00	09000 CLINIC	202,882		202,882	0	202,882 90.00
90.01	09001 WOUND CARE	764,391		764,391	0	764,391 90.01
91.00	09100 EMERGENCY	4,811,113		4,811,113	0	4,811,113 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,595,792		1,595,792	0	1,595,792 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	0		0	0	0 116.00
200.00	Subtotal (see instructions)	38,692,848	0	38,692,848	0	38,692,848 200.00
201.00	Less Observation Beds	1,595,792		1,595,792	0	1,595,792 201.00
202.00	Total (see instructions)	37,097,056	0	37,097,056	0	37,097,056 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,106,094		1,106,094		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	445,257	6,424,272	6,869,529	0.333933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	31,264	843,856	875,120	0.018946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,232,414	20,902,581	22,134,995	0.126684	54.00
60.00	06000	LABORATORY	1,706,983	14,563,009	16,269,992	0.151960	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	40,883	213,754	254,637	0.212754	63.00
65.00	06500	RESPIRATORY THERAPY	537,431	616,579	1,154,010	0.692121	65.00
66.00	06600	PHYSICAL THERAPY	379,675	2,998,665	3,378,340	0.534965	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,836	593,906	801,742	0.409781	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,600	653,240	669,840	0.017431	69.00
69.01	06901	CARDIAC REHABILITATION	0	350,583	350,583	0.418366	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,013,582	1,957,252	2,970,834	0.306873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,343	263,936	336,279	0.540263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,024,360	4,840,031	9,864,391	0.338514	73.00
76.00	03020	ONCOLOGY	4,784	498,058	502,842	0.776761	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,853,355	5,853,355	1.271941	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	553,419	553,419	2.930315	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	6,197	6,197	51.717767	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	546,537	546,537	2.070295	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	156,878	156,878	2.193003	88.04
90.00	09000	CLINIC	0	12,772	12,772	15.884904	90.00
90.01	09001	WOUND CARE	6,067	1,943,649	1,949,716	0.392052	90.01
91.00	09100	EMERGENCY	229,339	6,575,164	6,804,503	0.707048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	861,345	863,345	1.848383	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	12,056,912	72,229,038	84,285,950		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,056,912	72,229,038	84,285,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet C Part I Date/Time Prepared: 2/25/2025 3:44 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	88.04
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
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				
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1305

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

Worksheet D
Part II
Date/Time Prepared:
2/25/2025 3:44 pm

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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	219,294	6,869,529	0.031923	122,563	3,913	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,736	875,120	0.001984	12,741	25	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	208,364	22,134,995	0.009413	264,169	2,487	54.00
60.00	06000	LABORATORY	89,379	16,269,992	0.005493	349,673	1,921	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,765	254,637	0.010859	16,421	178	63.00
65.00	06500	RESPIRATORY THERAPY	36,286	1,154,010	0.031443	174,142	5,476	65.00
66.00	06600	PHYSICAL THERAPY	86,559	3,378,340	0.025622	65,048	1,667	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,411	801,742	0.005502	39,606	218	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	537	669,840	0.000802	10,230	8	69.00
69.01	06901	CARDIAC REHABILITATION	16,664	350,583	0.047532	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,329	2,970,834	0.013575	140,981	1,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,025	336,279	0.014943	10,864	162	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,821	9,864,391	0.006977	405,051	2,826	73.00
76.00	03020	ONCOLOGY	39,135	502,842	0.077828	1,191	93	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	356,191	5,853,355	0.060852	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,548	553,419	0.057006	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,842	6,197	1.426819	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	20,321	546,537	0.037181	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,165	156,878	0.026549	0	0	88.04
90.00	09000	CLINIC	32,412	12,772	2.537739	0	0	90.00
90.01	09001	WOUND CARE	83,524	1,949,716	0.042839	0	0	90.01
91.00	09100	EMERGENCY	278,587	6,804,503	0.040942	31,990	1,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	150,904	863,345	0.174790	1,335	233	92.00
200.00		Total (lines 50 through 199)	1,785,799	83,179,856		1,646,005	22,431	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D Part IV Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description	Title XVIII						Total
	Hospital		Allied Health		Allied Health		
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-Stepdown Adjustments	Cost	Cost	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D Part IV Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Title XVIII Hospital Cost		
				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	6,869,529	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	875,120	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	22,134,995	0.000000	54.00
60.00 06000 LABORATORY	0	0	0	16,269,992	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	254,637	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	1,154,010	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	3,378,340	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	801,742	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	669,840	0.000000	69.00
69.01 06901 CARDIAC REHABILITATION	0	0	0	350,583	0.000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,970,834	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	336,279	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	9,864,391	0.000000	73.00
76.00 03020 ONCOLOGY	0	0	0	502,842	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	5,853,355	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	553,419	0.000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	6,197	0.000000	88.02
88.03 08803 RURAL HEALTH CLINIC IV	0	0	0	546,537	0.000000	88.03
88.04 08804 RURAL HEALTH CLINIC V	0	0	0	156,878	0.000000	88.04
90.00 09000 CLINIC	0	0	0	12,772	0.000000	90.00
90.01 09001 WOUND CARE	0	0	0	1,949,716	0.000000	90.01
91.00 09100 EMERGENCY	0	0	0	6,804,503	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	863,345	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	83,179,856		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D Part IV Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description		Title XVIII				Hospital	
		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)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	122,563	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	12,741	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	264,169	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	349,673	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	16,421	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	174,142	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	65,048	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	39,606	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	10,230	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	140,981	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,864	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	405,051	0	0	0	73.00
76.00	03020 ONCOLOGY	0.000000	1,191	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
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 WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.000000	31,990	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,335	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,646,005	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D Part V Date/Time Prepared: 2/25/2025 3:44 pm
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.333933	0	1,514,112	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.018946	0	180,062	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.126684	0	5,564,940	0	0	54.00
60.00 06000 LABORATORY	0.151960	0	4,541,058	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.212754	0	100,008	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.692121	0	131,370	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.534965	0	1,060,443	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.409781	0	145,651	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.017431	0	223,544	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0.418366	0	127,518	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.306873	0	563,452	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.540263	0	99,642	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.338514	0	3,884,283	525	0	73.00
76.00 03020 ONCOLOGY	0.776761	0	194,355	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
88.03 08803 RURAL HEALTH CLINIC IV						88.03
88.04 08804 RURAL HEALTH CLINIC V						88.04
90.00 09000 CLINIC	15.884904	0	9,200	0	0	90.00
90.01 09001 WOUND CARE	0.392052	0	509,484	0	0	90.01
91.00 09100 EMERGENCY	0.707048	0	1,399,143	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.848383	0	301,908	0	0	92.00
200.00 Subtotal (see instructions)		0	20,550,173	525	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	20,550,173	525	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D Part V Date/Time Prepared: 2/25/2025 3:44 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	505,612	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	3,411	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	704,989	0		54.00
60.00 06000 LABORATORY	690,059	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	21,277	0		63.00
65.00 06500 RESPIRATORY THERAPY	90,924	0		65.00
66.00 06600 PHYSICAL THERAPY	567,300	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	59,685	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	3,897	0		69.00
69.01 06901 CARDIAC REHABILITATION	53,349	0		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	172,908	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	53,833	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,314,884	178		73.00
76.00 03020 ONCOLOGY	150,967	0		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88.00
88.01 08801 RURAL HEALTH CLINIC II				88.01
88.02 08802 RURAL HEALTH CLINIC III				88.02
88.03 08803 RURAL HEALTH CLINIC IV				88.03
88.04 08804 RURAL HEALTH CLINIC V				88.04
90.00 09000 CLINIC	146,141	0		90.00
90.01 09001 WOUND CARE	199,744	0		90.01
91.00 09100 EMERGENCY	989,261	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	558,042	0		92.00
200.00 Subtotal (see instructions)	6,286,283	178		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	6,286,283	178		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,753 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,291 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)			775 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			55 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)			222 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			18 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)			167 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			378 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)			55 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)			222 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			266.32 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			266.32 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,898,506 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)			4,794 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)			44,475 25.00
26.00	Total swing-bed cost (see instructions)			905,928 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,992,578 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,992,578 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)			3,092.63 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,169,014 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)			1,169,014 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 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	42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					515,256 48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0 48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,684,270 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)					170,095 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					686,564 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					856,659 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)					516 87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 pm	
Cost Center Description		Title XVIII		Hospital		Cost	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,092.62	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,595,792	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	463,224	4,898,506	0.094564	1,595,792	150,904	90.00
91.00	Nursing Program cost	0	4,898,506	0.000000	1,595,792	0	91.00
92.00	Allied health cost	0	4,898,506	0.000000	1,595,792	0	92.00
93.00	All other Medical Education	0	4,898,506	0.000000	1,595,792	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,753 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,291 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)			775 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			277 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			18 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)			167 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			7 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			266.32 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			266.32 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,898,506 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)			4,794 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)			44,475 25.00
26.00	Total swing-bed cost (see instructions)			905,928 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,992,578 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,992,578 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)			3,092.63 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			21,648 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)			21,648 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 pm	
Cost Center Description			Title XIX		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				19,700	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)				41,348	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
55.01	Permanent adjustment amount per discharge				0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00	55.02
55.03	CAR T-cell amount paid as an interim payment				0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				516	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305		Period: From 10/01/2023 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 2/25/2025 3:44 pm	
Cost Center Description		Title XIX		Hospital		Cost	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,092.62	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,595,792	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	463,224	4,898,506	0.094564	1,595,792	150,904	90.00
91.00	Nursing Program cost	0	4,898,506	0.000000	1,595,792	0	91.00
92.00	Allied health cost	0	4,898,506	0.000000	1,595,792	0	92.00
93.00	All other Medical Education	0	4,898,506	0.000000	1,595,792	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		447,517		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.333933	122,563	40,928	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.018946	12,741	241	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.126684	264,169	33,466	54.00
60.00	06000 LABORATORY	0.151960	349,673	53,136	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.212754	16,421	3,494	63.00
65.00	06500 RESPIRATORY THERAPY	0.692121	174,142	120,527	65.00
66.00	06600 PHYSICAL THERAPY	0.534965	65,048	34,798	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.409781	39,606	16,230	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.017431	10,230	178	69.00
69.01	06901 CARDIAC REHABILITATION	0.418366	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.306873	140,981	43,263	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.540263	10,864	5,869	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.338514	405,051	137,115	73.00
76.00	03020 ONCOLOGY	0.776761	1,191	925	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000 CLINIC	15.884904	0	0	90.00
90.01	09001 WOUND CARE	0.392052	0	0	90.01
91.00	09100 EMERGENCY	0.707048	31,990	22,618	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.848383	1,335	2,468	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,646,005	515,256	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,646,005		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 2/25/2025 3:44 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		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	0.333933	7,199	2,404 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.018946	1,536	29 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126684	40,192	5,092 54.00
60.00	06000	LABORATORY	0.151960	49,138	7,467 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.212754	2,053	437 63.00
65.00	06500	RESPIRATORY THERAPY	0.692121	28,205	19,521 65.00
66.00	06600	PHYSICAL THERAPY	0.534965	109,995	58,843 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.409781	54,771	22,444 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.017431	480	8 69.00
69.01	06901	CARDIAC REHABILITATION	0.418366	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.306873	39,517	12,127 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540263	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338514	61,415	20,790 73.00
76.00	03020	ONCOLOGY	0.776761	0	0 76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0 88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0 88.04
90.00	09000	CLINIC	15.884904	0	0 90.00
90.01	09001	WOUND CARE	0.392052	0	0 90.01
91.00	09100	EMERGENCY	0.707048	1,661	1,174 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848383	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		396,162	150,336 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		396,162	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 2/25/2025 3:44 pm	
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		9,027	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.333933	5,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018946	550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126684	7,509	54.00
60.00	06000	LABORATORY	0.151960	22,929	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.212754	324	63.00
65.00	06500	RESPIRATORY THERAPY	0.692121	2,089	65.00
66.00	06600	PHYSICAL THERAPY	0.534965	834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.409781	424	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.017431	140	69.00
69.01	06901	CARDIAC REHABILITATION	0.418366	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.306873	9,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338514	13,443	73.00
76.00	03020	ONCOLOGY	0.776761	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.271941	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.930315	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	51.717767	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.070295	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	2.193003	0	88.04
90.00	09000	CLINIC	15.884904	0	90.00
90.01	09001	WOUND CARE	0.392052	439	90.01
91.00	09100	EMERGENCY	0.707048	5,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848383	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,733	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)		68,733	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1305 Component CCN: 15-Z305	Period: From 10/01/2023 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 2/25/2025 3:44 pm	
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	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
60.00	06000	LABORATORY	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	88.04
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CARE	0.000000	0	90.01
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E Part B Date/Time Prepared: 2/25/2025 3:44 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,286,461 1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)			0 2.00
3.00	OPPTS or REH payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,286,461 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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			6,349,326 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)			66,973 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,203,315 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,079,038 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)			0 28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			3,079,038 30.00
31.00	Primary payer payments			4,828 31.00
32.00	Subtotal (line 30 minus line 31)			3,074,210 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)			153,859 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			100,008 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			143,515 36.00
37.00	Subtotal (see instructions)			3,174,218 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)			0 39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0 39.75
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,174,218 40.00
40.01	Sequestration adjustment (see instructions)			63,484 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,439,443 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-328,709 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E Part B Date/Time Prepared: 2/25/2025 3:44 pm
		Title XVIII	Hospital	Cost
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2025 3:44 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		1,298,442		3,439,443	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	07/03/2024	138,500		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)		138,500		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)		1,436,942		3,439,443	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	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		86,643		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		328,709	6.02	
7.00	Total Medicare program liability (see instructions)		1,523,585		3,110,734	7.00	
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305
Component CCN: 15-Z305

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2025 3:44 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		830,866		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	07/03/2024	33,400		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)		33,400		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)		864,266		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		123,135		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		987,401		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E-1 Part II Date/Time Prepared: 2/25/2025 3:44 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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E-2
		Component CCN: 15-Z305		Date/Time Prepared: 2/25/2025 3:44 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)	865,226	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)	151,839	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	277	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)	1,017,065	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,017,065	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	2,053	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,015,012	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,460	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,007,552	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)	1,007,552	0	19.00
19.01	Sequestration adjustment (see instructions)	20,151	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	864,266	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)	123,135	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
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1305	Period: From 10/01/2023	Worksheet E-2
		Component CCN: 15-Z305	To 09/30/2024	Date/Time Prepared: 2/25/2025 3:44 pm
		Title XIX	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison 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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E-3 Part V Date/Time Prepared: 2/25/2025 3:44 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,684,270 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
3.01	Cellular therapy acquisition cost (see instructions)			0 3.01
4.00	Subtotal (sum of lines 1 through 3.01)			1,684,270 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,701,113 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,701,113 19.00
20.00	Deductibles (exclude professional component)			148,387 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,552,726 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,552,726 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,004 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			1,953 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,554 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,554,679 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)			1,554,679 30.00
30.01	Sequestration adjustment (see instructions)			31,094 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			1,436,942 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			86,643 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 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: 15-1305	Period: From 10/01/2023 To 09/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2025 3:44 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		41,348		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)		41,348	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)		41,348	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		9,027		8.00
9.00	Ancillary service charges		68,733	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		77,760	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		77,760	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		36,412	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)		41,348	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		41,348	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)		41,348	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		41,348	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		41,348	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)		41,348	0	40.00
41.00	Interim payments		28,416	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		12,932	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: 15-1305

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

Worksheet G
Date/Time Prepared:
2/25/2025 3:44 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	607,017	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	18,153,741	0	0	0	4.00
5.00	Other receivable	1,382,948	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,340,729	0	0	0	6.00
7.00	Inventory	1,108,864	0	0	0	7.00
8.00	Prepaid expenses	213,719	0	0	0	8.00
9.00	Other current assets	3,976,870	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)	14,102,430	0	0	0	11.00
FIXED ASSETS						
12.00	Land	302,662	0	0	0	12.00
13.00	Land improvements	432,722	0	0	0	13.00
14.00	Accumulated depreciation	-454,776	0	0	0	14.00
15.00	Buildings	13,262,158	0	0	0	15.00
16.00	Accumulated depreciation	-10,100,235	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-208,863	0	0	0	18.00
19.00	Fixed equipment	7,978,297	0	0	0	19.00
20.00	Accumulated depreciation	-8,319,079	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	18,986,409	0	0	0	23.00
24.00	Accumulated depreciation	-9,883,753	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,182,597	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	13,734,479	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,734,479	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,019,506	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,312,519	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,405,816	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	607,919	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,204,129	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,530,383	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,126,675	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-2,130,017	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,996,658	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,527,041	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,492,465				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)	29,492,465	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,019,506	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1305

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

Worksheet G-1

Date/Time Prepared:
2/25/2025 3:44 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		26,728,182		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,764,290		0		2.00
3.00	Total (sum of line 1 and line 2)		29,492,472		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,492,472		0		11.00
12.00	ROUNDING	7		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)		7		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,492,465		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	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: 15-1305

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2025 3:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,270,817		1,270,817	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	107,116		107,116	5.00
6.00	Swing bed - NF	71,539		71,539	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,449,472		1,449,472	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,449,472		1,449,472	17.00
18.00	Ancillary services	10,281,906	57,757,566	68,039,472	18.00
19.00	Outpatient services	229,339	7,451,281	7,680,620	19.00
20.00	RURAL HEALTH CLINIC	0	5,853,355	5,853,355	20.00
20.01	RURAL HEALTH CLINIC II	0	553,419	553,419	20.01
20.02	RURAL HEALTH CLINIC III	0	6,197	6,197	20.02
20.03	RURAL HEALTH CLINIC IV	0	546,537	546,537	20.03
20.04	RURAL HEALTH CLINIC V	0	156,878	156,878	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-PROVIDER BASED	0	167,440	167,440	27.00
27.01	PHYSICIAN FEES	267,402	2,466,291	2,733,693	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,228,119	74,958,964	87,187,083	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,711,508		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)		44,711,508		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1305

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

Worksheet G-3

Date/Time Prepared:
2/25/2025 3:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,187,083	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,787,142	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,399,941	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,711,508	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,311,567	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,794,326	24.00
24.01	RENTAL INCOME	49,581	24.01
24.02	NON OPERATING	231,950	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,075,857	25.00
26.00	Total (line 5 plus line 25)	2,764,290	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,764,290	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-1

Component CCN: 15-8512

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 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	3,196,513	25,000	3,221,513	-1,995,052	1,226,461	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,096,684	129,782	1,226,466	5,212	1,231,678	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	205,317	0	205,317	0	205,317	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	57,824	0	57,824	33,383	91,207	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	616,436	0	616,436	0	616,436	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,172,774	154,782	5,327,556	-1,956,457	3,371,099	10.00
11.00	Physician Services Under Agreement	0	0	0	-44,694	-44,694	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	-44,694	-44,694	14.00
15.00	Medical Supplies	0	41,564	41,564	-6,034	35,530	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,564	41,564	-6,034	35,530	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,172,774	196,346	5,369,120	-2,007,185	3,361,935	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	20,687	20,687	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	20,687	20,687	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	152,294	152,294	-7,032	145,262	29.00
30.00	Administrative Costs	735,422	306,256	1,041,678	-338,175	703,503	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	735,422	458,550	1,193,972	-345,207	848,765	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,908,196	654,896	6,563,092	-2,331,705	4,231,387	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period:	Worksheet M-1
	Component CCN: 15-8512	From 10/01/2023 To 09/30/2024	Date/Time Prepared: 2/25/2025 3:44 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	1,226,461
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	1,231,678
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	205,317
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	91,207
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	616,436
10.00	Subtotal (sum of lines 1 through 9)	0	3,371,099
11.00	Physician Services Under Agreement	0	-44,694
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	-44,694
15.00	Medical Supplies	0	35,530
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	35,530
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,361,935
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	20,687
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	20,687
FACILITY OVERHEAD			
29.00	Facility Costs	0	145,262
30.00	Administrative Costs	0	703,503
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	848,765
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,231,387

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-1

Component CCN: 15-8527

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	Trial Balance (col. 3 + col. 4)	5.00
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	81,097	50,000	131,097	337,961	469,058	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	225,618	0	225,618	-116,502	109,116	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	95,887	0	95,887	0	95,887	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	75,782	0	75,782	0	75,782	9.00
10.00	Subtotal (sum of lines 1 through 9)	478,384	50,000	528,384	221,459	749,843	10.00
11.00	Physician Services Under Agreement	0	0	0	14,421	14,421	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	14,421	14,421	14.00
15.00	Medical Supplies	0	13,376	13,376	1,947	15,323	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,376	13,376	1,947	15,323	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	478,384	63,376	541,760	237,827	779,587	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	32,920	32,920	2,269	35,189	29.00
30.00	Administrative Costs	79,543	23,799	103,342	2,415	105,757	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,543	56,719	136,262	4,684	140,946	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	557,927	120,095	678,022	242,511	920,533	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period:	Worksheet M-1
	Component CCN: 15-8527	From 10/01/2023 To 09/30/2024	Date/Time Prepared: 2/25/2025 3:44 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	469,058
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	109,116
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	95,887
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	75,782
10.00	Subtotal (sum of lines 1 through 9)	0	749,843
11.00	Physician Services Under Agreement	0	14,421
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	14,421
15.00	Medical Supplies	0	15,323
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	15,323
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	779,587
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	35,189
30.00	Administrative Costs	0	105,757
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	140,946
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	920,533

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305
Component CCN: 15-8528

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

Worksheet M-1
Date/Time Prepared:
2/25/2025 3:44 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	0	0	0	20,358	20,358	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	-2,000	-2,000	108,719	106,719	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	-2,000	-2,000	129,077	127,077	10.00
11.00	Physician Services Under Agreement	0	0	0	7,662	7,662	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	7,662	7,662	14.00
15.00	Medical Supplies	0	1,992	1,992	1,034	3,026	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,992	1,992	1,034	3,026	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	-8	-8	137,773	137,765	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	6,485	6,485	1,205	7,690	29.00
30.00	Administrative Costs	540	9,031	9,571	1,283	10,854	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	540	15,516	16,056	2,488	18,544	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	540	15,508	16,048	140,261	156,309	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period:	Worksheet M-1
	Component CCN: 15-8528	From 10/01/2023 To 09/30/2024	Date/Time Prepared: 2/25/2025 3:44 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	20,358
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	106,719
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	127,077
11.00	Physician Services Under Agreement	0	7,662
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	7,662
15.00	Medical Supplies	0	3,026
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs		
21.00	Subtotal (sum of lines 15 through 20)	0	3,026
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	137,765
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	7,690
30.00	Administrative Costs	0	10,854
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	18,544
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	156,309

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-1

Component CCN: 15-8554

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 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	297,549	15,000	312,549	20,358	332,907	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	119,631	12,000	131,631	0	131,631	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	76,394	0	76,394	0	76,394	9.00
10.00	Subtotal (sum of lines 1 through 9)	493,574	27,000	520,574	20,358	540,932	10.00
11.00	Physician Services Under Agreement	0	0	0	18,256	18,256	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	18,256	18,256	14.00
15.00	Medical Supplies	0	0	0	2,465	2,465	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	2,465	2,465	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	493,574	27,000	520,574	41,079	561,653	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	46,379	46,379	57	46,436	29.00
30.00	Administrative Costs	35,579	26,689	62,268	3,057	65,325	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	35,579	73,068	108,647	3,114	111,761	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	529,153	100,068	629,221	44,193	673,414	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-1

Component CCN: 15-8554

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 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	0	332,907
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	131,631
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	76,394
10.00	Subtotal (sum of lines 1 through 9)	0	540,932
11.00	Physician Services Under Agreement	0	18,256
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	18,256
15.00	Medical Supplies	0	2,465
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	2,465
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	561,653
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	-11,729	34,707
30.00	Administrative Costs	0	65,325
31.00	Total Facility Overhead (sum of lines 29 and 30)	-11,729	100,032
32.00	Total facility costs (sum of lines 22, 28 and 31)	-11,729	661,685

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-1

Component CCN: 15-8581

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 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	104,054	0	104,054	90,465	194,519	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	12,000	12,000	400	12,400	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	42,369	0	42,369	0	42,369	9.00
10.00	Subtotal (sum of lines 1 through 9)	146,423	12,000	158,423	90,865	249,288	10.00
11.00	Physician Services Under Agreement	0	0	0	4,355	4,355	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	4,355	4,355	14.00
15.00	Medical Supplies	0	8,186	8,186	588	8,774	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,186	8,186	588	8,774	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	146,423	20,186	166,609	95,808	262,417	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	38,839	38,839	685	39,524	29.00
30.00	Administrative Costs	37,999	36,015	74,014	729	74,743	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,999	74,854	112,853	1,414	114,267	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	184,422	95,040	279,462	97,222	376,684	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period:	Worksheet M-1
	Component CCN: 15-8581	From 10/01/2023 To 09/30/2024	Date/Time Prepared: 2/25/2025 3:44 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	-107,580	86,939
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	12,400
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	42,369
10.00	Subtotal (sum of lines 1 through 9)	-107,580	141,708
11.00	Physician Services Under Agreement	0	4,355
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	4,355
15.00	Medical Supplies	0	8,774
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	8,774
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-107,580	154,837
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	39,524
30.00	Administrative Costs	-43,258	31,485
31.00	Total Facility Overhead (sum of lines 29 and 30)	-43,258	71,009
32.00	Total facility costs (sum of lines 22, 28 and 31)	-150,838	225,846

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2023 To 09/30/2024	Worksheet M-2 Date/Time Prepared: 2/25/2025 3:44 pm
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		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	3.78	15,680	4,200	15,876	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.56	7,591	2,100	3,276	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.34	23,271		19,152	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	1.86	1,536		1,536	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)	7.20	24,807		24,807	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				3,361,935	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				20,687	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,382,622	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.993884	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				848,765	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,213,734	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,062,499	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,062,499	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,037,653	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				7,399,588	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2023 To 09/30/2024	Worksheet M-2 Date/Time Prepared: 2/25/2025 3:44 pm
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		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.75	1,120	4,200	3,150	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.66	2,238	2,100	1,386	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	3,358		4,536	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)	1.41	3,358		4,536	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)				779,587	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)				779,587	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)				140,946	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				701,159	15.00
16.00	Total overhead (sum of lines 14 and 15)				842,105	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				842,105	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				842,105	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,621,692	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2023 To 09/30/2024	Worksheet M-2 Date/Time Prepared: 2/25/2025 3:44 pm
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		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	0.04	112	4,200	168	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.65	1,672	2,100	1,365	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.69	1,784		1,533	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
7.03	Marriage and Family Therapist	0.00	0			7.03
7.04	Mental Health Counselor	0.00	0			7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.69	1,784			8.00
9.00	Physician Services Under Agreements		0			9.00

						1.00
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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)					137,765
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					137,765
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					18,544
15.00	Parent provider overhead allocated to facility (see instructions)					164,186
16.00	Total overhead (sum of lines 14 and 15)					182,730
17.00	Allowable GME overhead (see instructions)					0
18.00	Enter the amount from line 16					182,730
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					182,730
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					320,495

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2023 To 09/30/2024	Worksheet M-2 Date/Time Prepared: 2/25/2025 3:44 pm
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		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	0.57	2,183	4,200	2,394	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.72	2,068	2,100	1,512	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.29	4,251		3,906	4,251
5.00	Visiting Nurse	0.00	0			0
6.00	Clinical Psychologist	0.00	0			0
7.00	Clinical Social Worker	0.00	0			0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0
7.03	Marriage and Family Therapist	0.00	0			0
7.04	Mental Health Counselor	0.00	0			0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.29	4,251			4,251
9.00	Physician Services Under Agreements		0			0
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				561,653	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)				561,653	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)				100,032	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				469,808	15.00
16.00	Total overhead (sum of lines 14 and 15)				569,840	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				569,840	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				569,840	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,131,493	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8581	Period: From 10/01/2023 To 09/30/2024	Worksheet M-2 Date/Time Prepared: 2/25/2025 3:44 pm
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	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	0.17	352	4,200	714	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.61	490	2,100	1,281	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	842		1,995	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	0.20	172		172	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)	0.98	1,014		2,167	8.00
9.00	Physician Services Under Agreements		0		0	9.00

						1.00
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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)					154,837
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					154,837
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					71,009
15.00	Parent provider overhead allocated to facility (see instructions)					118,188
16.00	Total overhead (sum of lines 14 and 15)					189,197
17.00	Allowable GME overhead (see instructions)					0
18.00	Enter the amount from line 16					189,197
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					189,197
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					344,034

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/25/2025 3:44 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)			7,399,588	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			148,311	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,251,277	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,807	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			24,807	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			292.31	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)	366.51	366.51		8.00
9.00	Rate for Program covered visits (see instructions)	292.31	292.31		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	1,507	4,617		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	440,511	1,349,595		11.00
12.00	Program covered visits for mental health services (from contractor records)	22	69		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	6,431	20,169		13.00
14.00	Limit adjustment for mental health services (see instructions)	6,431	20,169		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	1,816,706		16.00
16.01	Total program charges (see instructions)(from contractor's records)		906,408		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		70,007		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		140,315		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.)		1,264,078		16.04
16.05	Total program cost (see instructions)	0	1,404,393		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		96,293		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		147,834		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		1,404,393		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		52,942		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)		1,457,335		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)		1,457,335		26.00
26.01	Sequestration adjustment (see instructions)		29,147		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,139,353		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)		288,835		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/25/2025 3:44 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)			1,621,692	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,350	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,609,342	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,536	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,536	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			354.79	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)	272.42	272.42		8.00
9.00	Rate for Program covered visits (see instructions)	272.42	272.42		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	189	631		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,487	171,897		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	12		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	3,269		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	3,269		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	226,653		16.00
16.01	Total program charges (see instructions)(from contractor's records)		111,358		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,007		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,156		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.)		158,233		16.04
16.05	Total program cost (see instructions)	0	166,389		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,706		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,080		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		166,389		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,967		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)		173,356		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)		173,356		26.00
26.01	Sequestration adjustment (see instructions)		3,467		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		114,665		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)		55,224		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/25/2025 3:44 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)			320,495	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,295	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			308,200	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,784	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)			1,784	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			172.76	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)	325.24	325.24		8.00
9.00	Rate for Program covered visits (see instructions)	172.76	172.76		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	93	317		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	16,067	54,765		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	70,832		16.00
16.01	Total program charges (see instructions)(from contractor's records)		53,807		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,860		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,765		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		47,195		16.04
16.05	Total program cost (see instructions)	0	50,960		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,073		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,405		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		50,960		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,115		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)		56,075		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)		56,075		26.00
26.01	Sequestration adjustment (see instructions)		1,122		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		95,994		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)		-41,041		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/25/2025 3:44 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)			1,131,493	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			9,326	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,122,167	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,251	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,251	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			263.98	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)	313.66	313.66		8.00
9.00	Rate for Program covered visits (see instructions)	263.98	263.98		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	223	738		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	58,868	194,817		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	253,685		16.00
16.01	Total program charges (see instructions)(from contractor's records)		121,328		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,722		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,419		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		171,658		16.04
16.05	Total program cost (see instructions)	0	194,077		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,693		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,720		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		194,077		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,786		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)		195,863		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)		195,863		26.00
26.01	Sequestration adjustment (see instructions)		3,917		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		151,183		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)		40,763		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1305 Component CCN: 15-8581	Period: From 10/01/2023 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 2/25/2025 3:44 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)			344,034	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,729	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			342,305	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,167	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,167	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			157.96	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)	0	160		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	22,240		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	9		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,251		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,251		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	23,491		16.00
16.01	Total program charges (see instructions)(from contractor's records)		0		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		18,793		16.04
16.05	Total program cost (see instructions)	0	18,793		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		18,793		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		432		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)		19,225		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)		19,225		26.00
26.01	Sequestration adjustment (see instructions)		385		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		18,556		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)		284		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305
Component CCN: 15-8512

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

Worksheet M-4
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XVIII		RHC I	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,371,099	3,371,099	3,371,099	3,371,099	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000523	0.001813	0.000497	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,763	6,112	1,675	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	23,963	19,951	13,920	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	25,726	26,063	15,595	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,361,935	3,361,935	3,361,935	3,361,935	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	4,037,653	4,037,653	4,037,653	4,037,653	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007652	0.007752	0.004639	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	30,896	31,300	18,731	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	56,622	57,363	34,326	0	10.00	
11.00	Total number of injections/infusions (from your records)	122	423	116	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	464.11	135.61	295.91	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	36	169	45	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)	16,708	22,918	13,316	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)					148,311	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)					52,942	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305
Component CCN: 15-8527

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

Worksheet M-4
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XVIII		RHC II	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	749,843	749,843	749,843	749,843	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000769	0.001631	0.000163	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	577	1,223	122	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	1,909	1,266	840	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,486	2,489	962	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	779,587	779,587	779,587	779,587	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	842,105	842,105	842,105	842,105	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003189	0.003193	0.001234	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,685	2,689	1,039	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,171	5,178	2,001	0	10.00	
11.00	Total number of injections/infusions (from your records)	33	70	7	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	156.70	73.97	285.86	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	18	29	7	0	13.00	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,821	2,145	2,001	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)					12,350	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)					6,967	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305
Component CCN: 15-8528

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

Worksheet M-4
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	127,077	127,077	127,077	127,077	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001598	0.007189	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	203	914	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,419	1,749	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,622	2,663	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	137,765	137,765	137,765	137,765	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	182,730	182,730	182,730	182,730	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019032	0.019330	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,478	3,532	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,100	6,195	0	0	10.00
11.00	Total number of injections/infusions (from your records)	10	45	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	610.00	137.67	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	15	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)	3,050	2,065	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)				12,295	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)				5,115	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305

Period: From 10/01/2023

Worksheet M-4

Component CCN: 15-8554

To 09/30/2024

Date/Time Prepared: 2/25/2025 3:44 pm

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	540,932	540,932	540,932	540,932	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.003079	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	1,666	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	2,963	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,629	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	561,653	561,653	561,653	561,653	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	569,840	569,840	569,840	569,840	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.008242	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	4,697	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	9,326	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	94	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	99.21	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	18	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	1,786	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)				9,326	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)				1,786	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305
Component CCN: 15-8581

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

Worksheet M-4
Date/Time Prepared:
2/25/2025 3:44 pm

		Title XVIII		RHC V	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	141,708	141,708	141,708	141,708	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000486	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	69	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	709	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	778	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	154,837	154,837	154,837	154,837	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	189,197	189,197	189,197	189,197	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005025	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	951	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,729	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	432.25	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	432	0	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
					1.00	2.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				1,729	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				432	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/25/2025 3:44 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,139,353	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)		1,139,353	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		288,835	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,428,188	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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/25/2025 3:44 pm
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		114,665	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)		114,665	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		55,224	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		169,889	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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/25/2025 3:44 pm
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		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		95,994	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)		95,994	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		41,041	6.02
7.00	Total Medicare program liability (see instructions)		54,953	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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/25/2025 3:44 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			151,183	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)			151,183	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			40,763	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			191,946	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: 15-1305 Component CCN: 15-8581	Period: From 10/01/2023 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 2/25/2025 3:44 pm
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		RHC V	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		18,556	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)		18,556	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		284	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		18,840	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00