This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1341 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/22/2024 9:54 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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 PANA COMMUNITY HOSPITAL (14-1341) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jar	nes Moon	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	James Moon			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-235, 739	-522, 397	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	-298, 261	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		92, 892		0	10.00
10.01	RURAL HEALTH CLINIC II	0		248, 791		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		7, 803		0	10. 02
200.00	TOTAL	0	-534, 000				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.

Health Financial Systems PANA COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1341 Period: From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI C		Provi d	er CCN: 1	4-1341	Peri od: From 01/01/ To 12/31/	′2023 ′2023	Workshe Part I Date/Ti 5/22/20	me Pre	pared:
	1.00 Hospital and Hospital Health Care Co	amploy Ada	2.00		3. 00			4. 00			
1.00	Street: 101 E. 9TH STREET	nipi ex Auc	PO Box:								1.00
2.00	Ci ty: PANA		State: IL	Zip Cod	e: 62557-	1716 Count	y: CHRISTIA	N			2. 00
	-	Comp	onent Name	CCN	CBSA	Provi der			nt Syst		
				Number	Number	Туре	Certi fi ed	V 1,	0, or		-
			1.00	2.00	3. 00	4.00	5. 00	6.00	7. 00	8. 00	
	Hospital and Hospital-Based Componer	nt Identif		2.00	0.00	11.00	0.00	1 0.00	1 77 00	0.00	
3.00	Hospi tal		MUNITY HOSPITAL	141341	99914	1	11/01/2004	N	0	N	3. 00
4.00	Subprovider - IPF										4.00
5. 00 6. 00	Subprovi der - IRF Subprovi der - (Other)										5. 00 6. 00
7. 00	Swing Beds - SNF	PANA COM	MUNITY HOSPITAL	14Z341	99914		04/06/2004	N	0	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospi tal -Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA	OHAD COM	NTY HOME HEALTH	147299	99914		01/01/1985	N	P	l N	11. 00 12. 00
12.00	nospi tai -baseu nna	AGENCY	NIT HOWE HEALIN	14/299	99914		01/01/1905	I IN	"	I IN	12.00
13. 00	Separately Certified ASC	,.02.101									13.00
14.00	Hospi tal -Based Hospi ce		MUNITY HOSPITAL	141575	99914		08/31/1994				14. 00
45.00		HOSPI CE		4.0500			00/40/0040				45.00
15. 00	Hospital-Based Health Clinic - RHC	CLINIC PA	Y MEDICAL	148508	99914		03/18/2010	N	0	N	15. 00
15 01	Hospital-Based Health Clinic - RHC	1	I CAL GROUP	148633	99914		09/15/2022	N	0	N	15. 01
										'	
15. 02	Hospital-Based Health Clinic - RHC	COWDEN MI	EDICAL GROUP	148637	99914		08/01/2022	N	0	N	15. 02
1/ 00											16. 00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										17.00
18. 00	Renal Dialysis										18.00
19. 00	Other										19. 00
							From:		То		
20.00	Cost Depositing Desired (mm/dd/nnn)						1.00		12/31		20.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	023	12/31/	2023	20.00
21.00	Type of dontrol (see That dott ons)										21.00
						1. 00	2. 00		3. (00	
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it disproportionate share hospital adju					N					22. 00
	§412. 106? In column 1, enter "Y" for				`						
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
22. 01	Did this hospital receive interim UC					N	N				22. 01
	this cost reporting period? Enter in for the portion of the cost reporting										
	1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o										
00.05	instructions)		61 1 1105								00.05
22. 02	Is this a newly merged hospital that	•			LIMP	N	N				22. 02
	determined at cost report settlement 1, "Y" for yes or "N" for no, for the				ulli i						
	period prior to October 1. Enter in	•			no,						
	for the portion of the cost reportir										
22. 03	Did this hospital receive a geograph				I	N	N		N		22. 03
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in o										
	for the portion of the cost reportir		,		I						
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	- 100) : E	ci ili corullili	υ, ι IC	"						
22. 04	Did this hospital receive a geograph	nic reclas	sification from	urban to)						22. 04
	rural as a result of the revised OME										
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reportir in column 2, "Y" for yes or "N" for				"						
	reporting period occurring on or aft										
	Does this hospital contain at least	100 but n	ot more than 49	9 beds (a	I						
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. 105)?	Enter in column	1 3, "Y" f	or						
	lyes of 14 for 110.				I		Ţ	ļ			I

	Financial Systems PANA C TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Y HOSPITAL Provider CO	N: 14_1241	Peri od:	LIEU	u of For Workshe		
HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider Co	JN: 14-1341	From 01/01/ To 12/31/		Part I Date/Ti 5/22/20	me Pre	pared:
						V 1. 00	XVIII	XI X 3. 00	
	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this c "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFR which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb	resider column ost rep Worksh applica 413.77 on duty	nts in approved n 1. If column porting period' neet E-4. If co able. For cost 7(e)(1)(iv) an n, if the respondant	d GME program 1 is "Y", di P Enter "Y" blumn 2 is "N reporting pend (v), regar busse to line blete Workshe	ns trained d for yes or I", eriods dless of 56 is "Y"	N. N	2.00	3.00	57.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		o as				
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	NAHE 413.8 Y/N	5 Workshee Line	#	Pass-Th Qualifi Criterio	cation	59. 00
				1. 00	2.00		3. 0	00	
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. :R) NAHE	see If column 1	N					60.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1. 00	2. 00	3. 00	4.00		5. 0		
61. 01 61. 02 61. 03 61. 04 61. 05	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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) Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 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) 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)	N	ogram Name	Program Coc	le Unwei ahte	0. 00	Unwei c		61. 0.
		Pro	ogram Name 1.00	Program Coc	le Unweighter FTE Cou	nt	Unweig Direct (Cou 4.(ME FTE	
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. 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,			2.00	3.30	0.00		0.00	61. 10

Health Financial Systems		OMMUNITY HOSPITAL			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COM	IPLEX IDENTIFICATION DA	TA Provi der C	CN: 14-1341	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/22/2024 9:5	pared:
					1. 00	
ACA Provisions Affecting the H 62.00 Enter the number of FTE reside				riod for which	0.00	62.00
your hospital received HRSA PC 62.01 Enter the number of FTE reside	RE funding (see instruc	tions)				62. 01
during in this cost reporting	period of HRSA THC prog	ram. (see instructio			0.00	02.01
Teaching Hospitals that Claim 63.00 Has your facility trained resid	dents in nonprovider se	ettings during this c			N	63. 00
"Y" for yes or "N" for no in c	olumn 1. If yes, comple	ete lines 64 through	67. (see inst Unweighted		Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te			
Section 5504 of the ACA Base Y	ear FTE Residents in No	onprovider Settings	1.00 This base yea	2.00 ar is your cost r	a.00 eporting	
period that begins on or after 64.00 Enter in column 1, if line 63			0.	00 0.00	0. 000000	64 00
in the base year period, the n	umber of unweighted non	i-primary care		0.00	0.00000	0 11 00
resident FTEs attributable to settings. Enter in column 2 t	ne number of unweighted	l non-primary care				
resident FTEs that trained in of (column 1 divided by (column						
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der		4))	
	1.00	2. 00	Si te 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)			Unwei ghted		0.000000 Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te		2))	
Section 5504 of the ACA Curren		n Nonprovider Setting				
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1)	f unweighted non-primar occurring in all nonpr f unweighted non-primar tal. Enter in column 3	0.	0.00	0. 000000	66.00	
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4.00	5. 00	

Health Financial Systems PANA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1341 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/22/2024 9:54 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 67.00 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) 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)
68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 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? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71 00 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) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 85 00 N Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 Ν 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.

Enter "Y" for yes or "N" for no in column 2. (see instructi	Enter "Y" for yes or "N" for no in column 2. (see instructions)						
107.01 If this facility is a REH (line 3, column 4, is "12"), is it	t eligible for	cost			107. 01		
reimbursement for I&R training programs? Enter "Y" for yes of	or "N" for no.	(see					
instructions)							
108.00 Is this a rural hospital qualifying for an exception to the	08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See						
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							
	Physi cal	Occupati onal	Speech	Respi ratory			
	1.00	2.00	3. 00	4. 00			
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00		
therapy services provided by outside supplier? Enter "Y"							
for yes or "N" for no for each therapy.							

ealth Financial Systems PANA COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid	der CCN: 14-1341	Period:	Worksheet S	-2
		From 01/01/2023 To 12/31/2023	Part I Date/Time Pr	repare
			5/22/2024 9:	: 54 ar
0.00 Did this hospital participate in the Rural Community Hospital Demonst	tration project (\$4104	1. 00 N	110
Demonstration)for the current cost reporting period? Enter "Y" for ye complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-applicable.	es or "N" for no.	If yes,	IV	110
		1. 00	2. 00	
1.00 If this facility qualifies as a CAH, did it participate in the Fronti Health Integration Project (FCHIP) demonstration for this cost report "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participatin Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	ting period? Ente s Y, enter the ng in column 2.	N		111
	1.00	2. 00	3. 00	_
2.00 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 demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Wiscoll property Cont Pennstrian Informations				112
Miscellaneous Cost Reporting Information 5.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for	no N			0115
in column 1. If column 1 is yes, enter the method used (A, B, or E on 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 the definition in CMS Pub. 15-1, chapter 22, \$2208.1. 6.00 s this facility classified as a referral center? Enter "Y" for yes o	on			116
"N" for no. 7.00 s this facility legally-required to carry malpractice insurance? Ent				117
"Y" for yes or "N" for no. 8.00 s the malpractice insurance a claims-made or occurrence policy? Ente		2		118
if the policy is claim-made. Enter 2 if the policy is occurrence.			Insurance	110
If the policy is craim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
		Losses 2.00	Insurance 3.00	
	Premi ums	Losses 2. 00 98 48, 997	3.00	
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost center ot Administrative and General? If yes, submit supporting schedule listiand amounts contained therein.	Premi ums 1.00 65,0 ther than the	Losses 2.00		0118
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listicand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see	1.00 65,6 ther than the ng cost centers s provision in AC, "Y" for yes or for the Outpatien	Losses 2.00 598 48,997 1.00 N	3.00	0118
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listi and amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies fHold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable de	1.00 65,6 ther than the ng cost centers s provision in AC, 1, "Y" for yes or for the Outpatien instructions)	Losses 2.00 598 48,997 1.00 N	3.00	0 118 118 119 120
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8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listiand amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies feld Hold Harmless provision in ACA \$3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable de patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal theare related taxes as defined in \$Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included. 8.00 Did the facility and/or its subproviders (if applicable) purchase pro services, e.g., legal, accounting, tax preparation, bookkeeping, payr management/consulting services, from an unrelated organization? In co for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ent "N" for no.	Premiums 1.00 65,6 ther than the ng cost centers s provision in AC, "Y" for yes or for the Outpatien instructions) evices charged to s1903(w)(3) of the enter in column s1 offessional column 1, enter "Y" than 50% of total diorganizations	Losses 2.00 698 48,997 1.00 N A N t Y N Y	3.00	0 118 118 119 120 122
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listi and amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies f Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implantable de patients? Enter "Y" for yes or "N" for no. 4.00 Does the cost report contain heal thcare related taxes as defined in § Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included. 5.00 Did the facility and/or its subproviders (if applicable) purchase pro services, e.g., legal, accounting, tax preparation, bookkeeping, payr management/consulting services, from an unrelated organization? In co for yes or "N" for no. 6.1 If column 1 is "Y", were the majority of the expenses, i.e., greater professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ent "N" for no. 6. Certified Transplant Center Information	Premiums 1.00 65,0 ther than the ng cost centers s provision in AC, 1, "Y" for yes or for the Outpatien instructions) evices charged to s1903(w) (3) of the enter in column in the c	Losses 2.00 698 48,997 1.00 N A N t Y N Y	3.00 2.00 N	0 118 118 111 120 121 122
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listicand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 DIs this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implantable depatients? Enter "Y" for yes or "N" for no. 4.00 Does the cost report contain heal thcare related taxes as defined in § Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included. 5.00 Did the facility and/or its subproviders (if applicable) purchase propervices, e.g., legal, accounting, tax preparation, bookkeeping, payr management/consulting services, from an unrelated organization? In conforty yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ent "N" for no. Certified Transplant Center Information 5.00 Does this facility operate a Medicare-certified transplant center? En and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) belo	Premiums 1.00 65,6 ther than the ng cost centers s provision in AC, 1, "Y" for yes or for the Outpatien instructions) evices charged to single of the enter in column in the enter in column in the enter "Y" than 50% of total diorganizations ter "Y" for yes owner "Y" for yes owne	Losses 2.00 698 48,997 1.00 N N Y N Y N N N	3.00 2.00 N	0 118 118 119 120 122 123
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ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE		IITY HOSPITAL Provider CC	N: 14-1341	Peri od:		u of Form CMS- Worksheet S-2	
				From O	1/01/2023 2/31/2023	Part I Date/Time Pro 5/22/2024 9:5	epared
		·			1 00	2.00	_
31.00 If this is a Medicare-certified ir			erti fi cati		1. 00	2.00	131. (
32.00 If this is a Medicare-certified is in column 1 and termination date,	slet transplant program,	enter the certif	ication da	te			132. (
33.00 Removed and reserved 34.00 If this is a hospital-based organ in column 1 and termination date,	procurement organization	n (OPO), enter th	e OPO numb	er			133. (134. (
All Providers 10.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	If yes, and home	office cos		N		140.
1.00		. 00	1 110 11		3. 00	6.11	
If this facility is part of a chai home office and enter the home off				e name and	address	or the	
41. 00 Name:	Contractor's Name:			ctor's Nu	mber:		141.
12.00 Street:	PO Box:		7. 0				142.
43. 00 Ci ty:	State:		Zi p Co	ae:			143.
						1.00	
44.00 Are provider based physicians' cos	sts included in Workshee	t A?				Y	144. (
					1. 00	2.00	-
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no i clude Medicare utilization for no in column 2.	in column 1. If c on for this cost	olumn 1 is reporting			2.00	145.
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	column 1. (See CMS Pub.			lf	N	1.00	146.
7.00Was there a change in the statisti	cal basis? Enter "Y" for	r ves or "N" for	no			1.00 N	147.
18.00 Was there a change in the order of						N	148.
19.00 Was there a change to the simplifi	ed cost finding method?					N	149.
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	+
Does this facility contain a provi or charges? Enter "Y" for yes or "		an exemption from	the appli	cation of	the lowe	r of costs .13)	
5.00 Hospi tal		N	N		N	N	155.
66.00 Subprovi der – IPF 67.00 Subprovi der – IRF		N N	N N		N N	N N	156. 157.
8. 00 SUBPROVI DER							158.
9. 00 SNF		N	N		N	N	159.
O.OO HOME HEALTH AGENCY 1.OO CMHC		N	N N		N N	l N N	160. 161.
1. 00 OWITC			IN.		IN	1.00	- 101.
Multicampus 5.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campu	ses in dif	ferent CB	SAs?	N	165.
Enter "Y" for yes or "N" for no.	Name O	County 1.00	State 2.00	Zip Code 3.00	CBSA 4. 00	FTE/Campus 5.00	
consider the name in column to colum	U	1.00	2.00	3.00	4.00		0 166.
					,	1.00	
Health Information Technology (HI 57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	under §1886(n)? Enter	"Y" for yes or "	N" for no.		the	Y	167. 168.
reasonable cost incurred for the H	HT assets (see instructi	ions)		•		N	168.
8.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?					Jili P	"	

Health Financial Systems	,				u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 14-1341	Peri od	l:	Worksheet S-2	2
			From O	01/01/2023	Part I	
			To 1	12/31/2023		epared:
					5/22/2024 9: !	54 am
			Ве	egi nni ng	Endi ng	
				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 provide	r have any days for indiv	viduals enrolled in		N		171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of section	on			
1876 Medicare days in column 2. (see						

Health Financial Systems PANA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1341 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/22/2024 9:54 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1 00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α 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. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. 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 Y/N Date 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? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 02/28/2024 02/28/2024 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems PANA COMMUNIT				u of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 14-1341	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/22/2024 9:5	pared:
		Descri	pti on	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 (EXCER	PT CHILDRENS HO	OSPI TALS)		11.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportino	g period? If	yes, submit	N	27. 00
00.00	Interest Expense	topod i pto dupi	ing the cost	rananti na	Y	20.00
28. 00	Were new loans, mortgage agreements or letters of credit enperiod? If yes, see instructions.	. 0		28. 00		
29. 00	Did the provider have a funded depreciation account and/or I treated as a funded depreciation account? If yes, see instru	uctions		,	N	29. 00
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	rity with new o	debt? If yes	, see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new o	debt? If yes	, see	N	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care serv	vi ces furni shed	d through co	ntractual	Y	32.00
33. 00	arrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 appliers of Sec. 2135.2 appliers.	ctions.	-		Υ	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Were services furnished at the provider facility under an a	rrangement with	h provider-b	ased physicians?	Y	34. 0
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exis		ts with the	provi der-based	Υ	35. 0
	physicians during the cost reporting period? If yes, see in	structions.		Y/N	Data	
				1. 00	Date 2.00	
	Home Office Costs			1.00	2.00	
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 prollf yes, see instructions.	epared by the h	home office?			37. 00
	If line 36 is yes , was the fiscal year end of the home offi					38. 00
38. 00	the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes,					1
	If line 36 is yes, did the provider render services to other	r chain compone	ents? If yes	,		39. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the I	•	,			
39. 00	If line 36 is yes, did the provider render services to other see instructions.	home office? I	If yes, see			
39. 00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the linstructions.	•	If yes, see	2.	00	
39. 00 40. 00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the linstructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	home office? I	If yes, see		00	39. 00 40. 00 41. 00
9. 00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the linstructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	home office? I	If yes, see	2.	00	40.00
38. 00 39. 00 40. 00 41. 00 42. 00	If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the linstructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	home office? I	If yes, see	2.	00	40. 00

Health Financial Systems PA	NA COMMUNITY HOSPITAL In Lieu of Fo	rm CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO		eet S-2
	From 01/01/2023 Part To 12/31/2023 Date/T	
	5/22/2	024 9:54 am
	3. 00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/pos		41.00
held by the cost report preparer in columns 1, 2,	, and 3,	
respecti vel y.		
42.00 Enter the employer/company name of the cost report	rt	42. 00
preparer.		
43.00 Enter the telephone number and email address of		43. 00
report preparer in columns 1 and 2, respectively.		1

Health Financial Systems PANA CHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-1341

				-	Γο 12/31/2023	Date/Time Prep	
						5/22/2024 9: 54	4 am
						I/P Days / O/P	
	Component	Washabaat A	No of Dodo	Dod Davis		Visits / Trips Title V	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	ii tie v	
		Li ne No. 1.00	2. 00	Avai I abl e 3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	22	8, 030	15, 000. 00	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	22	0,030	13,000.00	O	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
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		22	8, 030	15, 000. 00	0	7. 00
7.00	beds) (see instructions)		22	0,000	10,000.00	Ŭ	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)		22	8, 030	15, 000. 00	0	14. 00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						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	HOSPI CE	116. 00	0	(24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25.00
26. 00	RHC (CONSOLI DATED)	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. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		22				27.00
28. 00	Observation Bed Days					0	28.00
29. 00	Ambul ance Tri ps						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		D		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	20.00	^			o	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	1		ا	34. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/22/2024 9:54 am

				'	0 12/01/2020	5/22/2024 9:5	4 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	oomponent.			Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10. 00	
	PART I - STATISTICAL DATA						1
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	336	6	616			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	0	23				2.00
3.00	HMO IPF Subprovider	0	23				3.00
4. 00	HMO IRF Subprovider		0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	907	Ö	1, 001			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	, , ,	ol	22			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 243	6	1, 639		•	7. 00
	beds) (see instructions)			•			
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			4 .00		450.00	13. 00
14.00	Total (see instructions)	1, 243	6	1, 639		150. 82	1
15.00	CAH visits	0 0	0	(15.00
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF	١	٩	· ·	,		15. 10 16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						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	4, 086	o	8, 343	0.00	19. 74	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0	0	C	0.00	5. 54	24. 00
24. 10	HOSPICE (non-distinct part)			ç)		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RHC (CONSOLI DATED)	2, 759	0	16, 051		23. 41	1
26. 01	RURAL HEALTH CLINIC II	1, 836	0	6, 957		15. 28	1
26. 02	RURAL HEALTH CLINIC III	416 0	0	3, 459			1
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	O O	۷	C	0. 00 0. 00		
28. 00	Total (sum of lines 14-26) Observation Bed Days		0	100		220. 60	28.00
29. 00	Ambulance Trips	0	٩	100	,		29.00
30. 00	Employee discount days (see instruction)			5	,		30.00
31. 00	Employee discount days (see l'histraction)			(31.00
32. 00	Labor & delivery days (see instructions)	0	o	(32.00
32. 01	Total ancillary labor & delivery room		آ	Ċ			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	C)		34. 00

Health Financial Systems PANA CHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

				10	12/31/2023	5/22/2024 9:5	
		Full Time Equivalents	<u> </u>	Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		(3	209	1.00
2. 00	HMO and other (see instructions)			0	6		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	(128	3	209	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	SUBPROVI DER						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.)	0.00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RHC (CONSOLI DATED)	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. 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	0.00					28.00
29. 00	Ambul ance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00							32.00
32. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
33. 00	LTCH site neutral days and discharges						33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34.00
34.00	Tremborary Exhauston Covin-19 Fue Acute Care			1			J 34. UU

Heal th	Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provi der C	F	eriod: rom 01/01/2023	Worksheet S-4	
			Component	CCN: 14-7299 To		5/22/2024 9: 5	
					Home Health Agency I	PPS	
					1.	00	
0.00	County				CHRI STI AN		0. 00
		1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4. 00	3.00	
1.00	Home Heal th Aide Hours	182	l e				1.00
2. 00	Unduplicated Census Count (see instructions)	241. 00	30.00		oyees (Full Ti		2. 00
				· ·			
			er of hours in	Staff	Contract	Total	
		your normal	work week				
				1.00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		0	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00				3. 00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 00 0. 00			4. 00 5. 00
6. 00	Direct Nursing Service			8. 65			6.00
7. 00	Nursi ng Supervi sor			0.00			7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 25 0. 00			8. 00 9. 00
10.00	Occupational Therapy Service			0.00			10.00
11. 00	Occupational Therapy Supervisor			0.00			11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 12 0. 00		0. 13 0. 00	12. 00 13. 00
14. 00	Medical Social Service			0.14			14. 00
15. 00	Medical Social Service Supervisor			0.00			
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. 15 0. 00			16. 00 17. 00
	Other (specify)			0.00			
						CBSA Data 1.00	
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00	Enter in column 1 the number of CBSAs where					2	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this co	ost reporting p	eriod (line 20	contains the	99914	20. 00
20. 01	Thrist code).					41180	20. 01
		Full E	oisodes Twith Outliers	LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers	With outiles	LUFA LPI Sodes	Epi sodes	1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 330	206	22	8	1, 566	21. 00
22. 00	Skilled Nursing Visit Charges	345, 285	53, 560	5, 708	2, 080	406, 633	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 695 442, 983		1		2, 032 531, 264	
25. 00	Occupational Therapy Visits	279			1, 310		25. 00
26. 00	Occupational Therapy Visit Charges	78, 120					
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	35 9, 800			0		27. 00 28. 00
29. 00	Medical Social Service Visits	11	5	0			29. 00
30.00	Medical Social Service Visit Charges	3, 559					30.00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	13 2, 033					31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	3, 363					33. 00
34. 00	29, and 31) Other Charges		0	o	0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	881, 780		_	3, 390		35. 00
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	381		35	0	416	36. 00
37. 00	Total Number of Outlier Episodes		30		0		37. 00
38. 00	Total Non-Routine Medical Supply Charges	7, 397	1, 165	36	95	8, 693	38. 00

	Financial Systems AL-BASED RHC/FQHC STATISTICAL DATA	PANA COMMUNITY		CN: 14-1341	Peri od:	eu of Form CMS Worksheet S-	
				CCN: 14-8508	From 01/01/2023 To 12/31/2023	Date/Time Pr	epared:
					RHC I	5/22/2024 9: Cost	54 am
					KHC I	COST	
					1.	00	
1. 00	Clinic Address and Identification Street				101 F 9TH STR	REET, SUITE 105	1.00
	1001		Ci	ty	State	ZIP Code	, , , , , ,
				00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County	<u> P.</u>	ANA			62557	2.00
						1.00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er "R" for rural	or "U" for u		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340			1			5. 00 6. 00
6. 00 7. 00	Appalachian Regional Commission	Juj, PHS ACL)					7.00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)			<u> </u>			9. 00
					1. 00	2. 00	+
10. 00	Does this facility operate as other than a ho	ospi tal -based RH	C or FQHC? Er	nter "Y" for	N		0 10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
	ineal of y	Sunda	ay	Me	onday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2. 00	3.00	4. 00	5. 00	
11. 00	CLINIC			08: 30	20: 00	08: 30	11.00
12.00	Have you received an approval for an evention	on to the produc	tivity otopda	ved2	1. 00 N	2. 00	12.00
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapter nter in colum	9, section nn 2 the	Y		13.00
13. 01	If line 13, column 1, is "Y", are you reporti in CMS Pub. 100-02, chapter 13, section 80.2) yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co comprised exclusively of new consolidated RHC)? Enter "Y" fo dated RHC groupi RHC grouping. onsolidated RHCs	r yes or "N" ngs and compl Consolidated in the group	for no. If ete a RHC groupings oing or	3		13. 01
					der name	2. 00	
14. 00	RHC/FQHC name, CCN			COMMUNITY MEI	1.00 DICAL CLINIC	148508	14.00
14. 01				PANA COMMUNITY MEI	DICAL CLINIC OF	148575	14. 01
14. 02				ASSUMPTI COMMUNITY MEI NOKOMIS	DICAL CLINIC OF	148574	14. 02
		Y/N	V	XVIII	XIX	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.	1.00	2.00	3.00	4.00	5. 00	15. 00
	XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						

Health Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1341	Peri od:	Worksheet S-8	
		Component	CCN: 14-8508	From 01/01/2023 To 12/31/2023		
				RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		CHRI STI AN				2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	20: 00	08: 30	20: 00	08: 30	20: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)				<u> </u>		
11. 00 CLINIC	08: 30	17: 00				11. 00

HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1341	Peri od:	Worksheet :	S-8	
			Component	CCN: 14-8633	From 01/01/202 To 12/31/202			
					RHC II	Cos		aiii
					1	1.00		
	Clinic Address and Identification					1.00		
00	Street	-			217 S LOCUST			1.
				ty	State	ZIP Code		
. 00	City, State, ZIP Code, County		PANA	00	2.00	3. 00 L 62557		2.
. 00	orty, State, Zir code, county		II ANA		'	L02337		۷.
						1.00		
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	ıl or "U" for ι				0	3.
					nt Award 1.00	2.00	-	
	Source of Federal Funds			l	1.00	2.00		
. 00	Community Health Center (Section 330(d), PHS	Act)						4.
. 00	Migrant Health Center (Section 329(d), PHS Ad							5.
. 00 . 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	U(d), PHS Act)						6. 7.
. 00 . 00	Look-Alikes							7. 8.
. 00	OTHER (SPECIFY)							9.
2 00	Dana this facility against as ather than a h	: +_!	NIC FOLICO F-	+ V	1.00	2. 00		10
0. 00	Does this facility operate as other than a holyes or "N" for no in column 1. If yes, indicates				N		٥	10.
	2. (Enter in subscripts of line 11 the type of hours.)							
	Thou 3.)							
		Sun	day	N	londay	Tuesday		
		from	to	from	to	from		
1 00	Facility hours of operations (1)	from	to	from 3.00	to 4.00	from 5.00		11
1. 00	Facility hours of operations (1)	from	to	from	to	from		11.
1. 00	CLI NI C	from 1.00	to 2.00	from 3.00	to 4.00	from 5.00		11.
2. 00	CLINIC Have you received an approval for an exception	from 1.00 on to the produ	to 2.00	from 3.00 08:30	20: 00 1. 00 N	from 5.00		12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined	from 1.00 on to the produ d in CMS Pub. 1	to 2.00 activity standa 00-04, chapter	from 3.00 08:30	to 4. 00	from 5.00	0	12.
2. 00	CLINIC Have you received an approval for an exception	from 1.00 on to the produ d in CMS Pub. 1 umn 1. If yes,	to 2.00 activity standa 00-04, chapter enter in colum	from 3.00 08:30 ord? 9, section in 2 the	20: 00 1. 00 N	from 5.00	0	12.
2. 00 3. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. In numbers below.	on to the produd in CMS Pub. 1 umn 1. If yes, List the names	to 2.00 activity standa 00-04, chapter enter in colum s of all provice	from 3.00 08:30 ord? 9, section 1 2 the 1 lers and	20: 00 1. 00 N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception of the state of the sta	on to the production of the pr	to 2.00 activity standa 00-04, chapter enter in colum s of all provic	from 3.00 08:30 ord? 9, section 1 2 the lers and 2s (as define	20: 00 1. 00 N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reporting CMS Pub. 100-02, chapter 13, section 80.2	from 1.00 on to the production CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f	to 2.00 activity standa 00-04, chapter enter in colum s of all provic	from 3.00 08:30 ord? 9, section 12 the elers and 2s (as define for no. If	20: 00 1. 00 N	from 5.00		11. 12. 13.
1. 00 2. 00 3. 00 3. 01	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. 1 cumn 1. If yes, List the names ing multiple cc)? Enter "Y" for dated RHC group	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC for yes or "N" bings and compl	from 3.00 08:30 ord? 9, section in 2 the ers and is (as define for no. If ete a	20: 00 1. 00 N N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC grouping. onsolidated RHC	to 2.00 activity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 ord? 9, section 1 2 the 1 lers and 0 s (as define 1 for no. If 1 ete a 1 RHC grouping	20: 00 1. 00 N N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC grouping. onsolidated RHC	to 2.00 activity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 ord? 9, section n 2 the lers and s (as define for no. If ete a RHC grouping ing or	20: 00 1. 00 N N	608: 30 2. 00		12. 13.
2. 00 3. 00	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC grouping. onsolidated RHC	to 2.00 activity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 rd? 9, section 12 the lers and 2s (as define for no. If ete a RHC grouping ing or	20: 00 1. 00 N N	from 5.00		12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC grouping. onsolidated RHC	to 2.00 activity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 rd? 9, section 12 the lers and 2s (as define for no. If ete a RHC grouping ing or	to 4.00 20:00 1.00 N N	60	0	12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception of the street of the stre	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reportin CMS Pub. 100-02, chapter 13, section 80.22 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names of ing multiple compared in the group ing. RHC grouping. Onsolidated RHC Cs in the group	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC for yes or "N" bings and compl Consolidated cs in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and es (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N S ider name 1.00	60	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reportin CMS Pub. 100-02, chapter 13, section 80.22 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. 1 umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provic consolidated RHC cor yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 20:00 1.00 N N N d N S ider name 1.00 XIX	CCN 2.00	0	12. 13.

Health Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1341	Peri od:	Worksheet S-8	-
		Component	CCN: 14-8633	From 01/01/2023 To 12/31/2023		
				RHC II	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		CHRI STI AN				2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	20: 00	08: 30	20: 00	08: 30	20: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)				<u> </u>		
11. 00 CLINIC	08: 30	17: 00				11. 00

Heal th	Financial Systems	PANA COMMUNIT	Y HOSPITAL		In Li	eu of Form CMS	S-2552
HOSPI 1	FAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component	CN: 14-1341 CCN: 14-8637	Period: From 01/01/2023 To 12/31/2023		repare
					RHC III	Cost	
					1	. 00	
	Clinic Address and Identification						
1. 00	Street				209 E ELM ST	1 710 0 1	1.
		-		00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		COWDEN 1.	00		62422	2.
	Tuespitti Biosp tous out a final final	"B" 6				1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u		nt Award	Date	0 3.
				Gra	1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.
6. 00 7. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(d), PHS ACL)					6. 7.
8. 00	Look-Alikes						8.
9.00	OTHER (SPECIFY)						9.
					1.00	2.00	
10. 00	Does this facility operate as other than a ho	enital based Di	UC or EOUC2 En	tor "V" for	1. 00 N	2. 00	0 10.
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	s in column	IV.		0 10.
	illoui s.)	Suno	lav	1	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			00. 20	20.00	00.20	
11.00	CLI NI C			08: 30	20: 00	08: 30	11.
					1. 00	2. 00	
12. 00	Have you received an approval for an exception				N		12.
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes, o	enter in colum	n 2 the	N		0 13.
10.00	numbers below.	and and the control of	1: ! 5::0	- (! 5'			0 40
13. 01	If line 13, column 1, is "Y", are you reporti in CMS Pub. 100-02, chapter 13, section 80.2) yes, enter in column 2 the number of consolic separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co comprised exclusively of new consolidated RHG)? Enter "Y" fo dated RHC group RHC grouping. onsolidated RHC	or yes or "N" ings and compl Consolidated s in the group	for no. If ete a RHC grouping			0 13.
	Transport and the grant of the sense of the total time	g. oup	· · · ʊ ·	Prov	ider name	CCN	
	Tana adam				1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	V//N		V/ / 1 1 1	V1.V	T-+-1 \(\tau \)	14.
		Y/N 1. 00	2. 00	3. 00	XI X 4. 00	Total Visits	5
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)	33	00	3. 00		3.00	15.

Health Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	3
		Component	CCN: 14-8637	From 01/01/2023 To 12/31/2023		epared: 64 am
				RHC III	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		SHELBY				2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	20: 00	08: 30	20: 00	08: 30	20: 00	11. 00
	Fri	day	Sa ⁻	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 30	17: 00				11. 00

Heal th Financi al Systems	111 +1-	Figure 1 Contains		DANIA COMMUNI	TV HOCDLTAI		I = 1 ! -	£ F CMC /	2552 40
Hospice CN: 14-1575 From O1/01/2023 PARTS THROUGH IV Date/Time Prepared: 5/22/2024 9:54 am			DATA	PANA COMMUNI		CN: 14_1341			
St. St.	1103111	AL-BASED HOSTICE TRENTITION	DATA				From 01/01/2023	PARTS I THROU	GH IV
Unduplicated Days					Hospi ce CC	N: 14-1575	To 12/31/2023		
Days Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Title XVIII Title XVIII Title XVIII Title XIX Title XVIII Title XIX All Other Total (sum of cols. 1, 2 & S)							Hospi ce I	3/22/2024 9.5	4 4111
Days Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Nursing Facility Skilled Nursing Facility Nursing Facility Skilled Skilled			Unduplicated				1103pr cc 1		
Skilled Nursing Facility									
Nursing Facility 5)			Title XVIII	Title XIX			All Other		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 1.00 2.00 3.00 4.00 5.00 6.00 1.00									
Number of patients receiving hospice care 1.00 2.00 3.00 4.00 5.00 6.00 1.00						Facility		5)	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 1.00			1 00	2 00		4.00	5.00	6 00	
1.00		PART I - ENROLLMENT DAVS FOR CO					3.00	0.00	
2. 00 Hospice Routine Home Care 2. 00 Hospice General Inpatient Care 4.00 Hospice General Inpatient Care 4.00 Hospice General Inpatient Care 4.00 Fortal Hospice Days 4.00 Fortal Hospice Care 6.00 Fortal Hospice Care 7.00 Total number of patients receiving 6.00 Fortal Hospice Care 7.00 Fortal Hospice Care 7.00 Fortal Hospice Care 7.00 Fortal Hospice Days 7.00 Fortal Hospice Care 7.00 7.00 Fortal Hospice Care 7.00	1.00			EKT ODG BEGTIMM	DEFORE COTE	1, 2010			1.00
4.00 Hospice General Inpatient Care 1.00 Total Hospice General Inpatient Care 1.00 Total Hospice Days 1.00 Total Hospice Days 1.00 Total number of patients receiving hospice care 1.00 Total number of unduplicated Continuous Care hours billable to Medicare 8.00 Average Length of Stay (line 5 / line 6) 9.00 Unduplicated census count 9.00 NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII									
Total Hospice Days	3.00	Hospice Inpatient Respite Care							3. 00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 6.00 Number of patients receiving hospice care 7.00 Total number of unduplicated Continuous Care hours billable to Medicare 8.00 Average Length of Stay (line 5 / line 6) 9.00 Unduplicated census count NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII Title XIX Other Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 10.00 Hospice Continuous Home Care 0 0 0 0 0 0 10.00 11.00 Hospice Routine Home Care 4, 440 102 151 4,693 11.00 12.00 Hospice Inpatient Respite Care 9 0 0 0 9 12.00 13.00 Hospice General Inpatient Care 0 0 0 0 0 13.00 14.00 Total Hospice Days 4,449 102 151 4,702 14.00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospice Inpatient Respite Care 0 0 0 0 15.00 15.00 Hospice Inpatient Respite Care 0 0 0 0 15.00	4.00	Hospice General Inpatient Care							4. 00
6.00 Number of patients receiving	5.00								5. 00
Note			REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
Total number of unduplicated Continuous Care hours billable to Medicare	6. 00								6. 00
Continuous Care hour's billable to Medicare	7 00								7 00
10 Note:	7.00								7.00
8.00 Average Length of Stay (line 5									
9.00 Unduplicated census count 9.00 NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII	8.00								8. 00
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII									
Title XVIII	9. 00	Unduplicated census count							9. 00
Col s. 1 through 3	NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
Name					Title XVIII	Title XIX	Other	Total (sum of	
1.00 2.00 3.00 4.00									
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 10.00 Hospice Continuous Home Care									
10.00 Hospi ce Conti nuous Home Care 0 0 0 0 0 0 10.00 11.00 12.00 15.00		DADT III FNDOLIMENT DAVC FOR	COCT DEPODIL N	DEDLODG DEGLA				4.00	
11.00	10 00		COST REPORTING	PERIODS BEGIN	INTING ON OR AFT	ER OCTOBER I		_	10.00
12.00 Hospi ce Inpatient Respite Care 9 0 0 9 12.00 13.00 Hospi ce General Inpatient Care 0 0 0 13.00 14.00 Total Hospi ce Days 4,449 102 151 4,702 14.00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospi ce Inpatient Respite Care 0 0 0 15.00 12.00 13.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00					1 110	1	-		
13.00 Hospice General Inpatient Care 0 0 0 0 13.00 14.00 Total Hospice Days 4,449 102 151 4,702 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospice Inpatient Respite Care 0 0 0 0 15.00					4, 440	j			
14. 00 Total Hospice Days 4,449 102 151 4,702 14. 00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15. 00 Hospice Inpatient Respite Care 0 0 0 0 15. 00					Ó		-	1	
15.00 Hospice Inpatient Respite Care 0 0 0 15.00					4, 449	1	02 151	4, 702	
			AL DATA FOR COS	ST REPORTING PE			R OCTOBER 1, 201		1
16.00 Hospice General Inpatient Care 0 0 0 16.00									
	16. 00	Hospice General Inpatient Care			0)	0 0	0	16. 00

ealth Financial Systems		NI TY HOSPI TAL			u of Form CMS-2	
OSPITAL UNCOMPENSATED AND INDIGENT C	ARE DATA	Provi der CC	N: 14-1341	Peri od: From 01/01/2023 To 12/31/2023		pared
					4.00	
PART I - HOSPITAL AND HOSPITAL	COMPLEY DATA				1. 00	
Uncompensated and Indigent Care						
00 Cost to charge ratio (see insti	ructions)				0. 407019	1. (
Medicaid (see instructions for					0. 10.01.	
00 Net revenue from Medicaid	· · · · · · · · · · · · · · · · · · ·				3, 240, 934	2. (
00 Did you receive DSH or suppleme	ental payments from Medicai	d?			Υ	3. (
00 If line 3 is yes, does line 2 i	nclude all DSH and/or supp	lemental payments	s from Medica	ni d?	N	4. 0
00 If line 4 is no, then enter DSA	Hand/or supplemental payme	ents from Medicaio	t		2, 859, 933	5. 0
00 Medicaid charges					15, 944, 540	6.0
00 Medicaid cost (line 1 times lin					6, 489, 731	7.0
00 Difference between net revenue					388, 864	8.0
Children's Health Insurance Pro		ons for each line	2)		0	9.0
D. 00 Stand-alone CHIP charges	11 P				0	10. (
1.00 Stand-alone CHIP cost (line 1	imes line 10)				0	11. (
2.00 Difference between net revenue		CHIP (see instruc	ctions)		Ö	12. (
Other state or local government						
3.00 Net revenue from state or local	indigent care program (No	t included on lir	nes 2, 5 or 9	9)	0	13.0
4.00 Charges for patients covered up 10)	nder state or local indigen	nt care program (N	Not included	in lines 6 or	0	14. 0
5.00 State or local indigent care p	rogram cost (line 1 times l	ine 14)			0	15. (
6.00 Difference between net revenue					0	16. (
Grants, donations and total unr instructions for each line)				gent care progran		
7.00 Private grants, donations, or e					0	17. (
B.00 Government grants, appropriation 9.00 Total unreimbursed cost for Medical Cost				· (oum of lines	22, 435	
9.00 Total unreimbursed cost for Med 8, 12 and 16)	ircard , ChiP and State and	i rocai indigent c	care programs	s (Sull of Times	388, 864	19. (
10, 12 2			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
Uncompensated care cost (see in		\		20 22 22		
0.00 Charity care charges and uninson 1.00 Cost of patients approved for 6			5, 49			20. (
instructions)		,	2, 2			21. (
2.00 Payments received from patients charity care	s for amounts previously wr	ritten off as	2, 7	6, 189	8, 938	22. (
3.00 Cost of charity care (see inst	ructions)			0 6, 190	6, 190	23.
					1. 00	
4.00 Does the amount on line 20 col. imposed on patients covered by			a Length of	stay limit	N	24. (
	medicald of other indigent marges for patient days bey				0	25. (

25. 01

26.00

27. 00

27.01

28.00

29.00

30.00

0

1, 785, 281

308, 847

475, 149

699, 551

705, 741

1, 094, 605 31. 00

1, 310, 132

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 | Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

25.01

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN: 14	4-1341	Peri od: From 01/01/2023 To 12/31/2023		pared
					1. 00	
	PART II - HOSPITAL DATA				•	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
. 00	Cost to charge ratio (see instructions)					1.
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid					2.
. 00	Did you receive DSH or supplemental payments from Medicaid?					3.
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	1 2	om Medica	ai d?		4.
. 00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid				5.
00	Medicaid charges					6.
. 00	Medicaid cost (line 1 times line 6)		>			7.
00	Difference between net revenue and costs for Medicaid program (s Children's Health Insurance Program (CHIP) (see instructions for		15)			8.
00	Net revenue from stand-alone CHIP	each Tine)			T	9.
0.00	Stand-alone CHIP charges					10.
	Stand-alone CHIP cost (line 1 times line 10)					111.
	Difference between net revenue and costs for stand-alone CHIP (s	see instruction	ns)			12.
. 00	Other state or local government indigent care program (see instr					12.
3. 00	Net revenue from state or local indigent care program (Not inclu					13.
4. 00	Charges for patients covered under state or local indigent care					14.
	10)					
5. 00	State or local indigent care program cost (line 1 times line 14))				15.
6. 00	Difference between net revenue and costs for state or local indi					16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/loc	cal indig	jent care progra	ms (see	
7. 00	Private grants, donations, or endowment income restricted to fur	0				17.
8. 00	Government grants, appropriations or transfers for support of ho					18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care	programs	s (sum of lines		19.
	8, 12 and 16)	Un	i nsured	Lacusod	Total (col. 1	
			ati ents	I nsured pati ents	+ col . 2)	
			1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)		1.00	2.00	J 3. 00	
0. 00	Charity care charges and uninsured discounts (see instructions)					20.
1. 00	Cost of patients approved for charity care and uninsured discour	nts (see				21.
	instructions)					
2. 00	Payments received from patients for amounts previously written c charity care	off as				22.
3. 00	Cost of charity care (see instructions)					23.
	· · · · · · · · · · · · · · · · · · ·	•				
					1. 00	
1. 00	Does the amount on line 20 col. 2, include charges for patient of	days beyond a I	ength of	stay limit		24.
	imposed on patients covered by Medicaid or other indigent care p					
. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e indigent care	e progran	n's length of		25.

25.01

26.00

27. 00

27. 01 28.00

29.00

30.00 31.00

25.01

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Health Financial Systems	PANA COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO	CN: 14-1341 F	Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/22/2024 9:54	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
· ·			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 CAP REL COSTS-BLDG & FIXT		1, 862, 034			1, 087, 009	1. 00
1. 01 00101 CAP REL COSTS-BLDG & FLXT NEW BDG EX		246, 781	246, 78		1, 109, 966	1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		755, 340	· ·		771, 000	2.00
3. 00 00300 OTHER CAP REL COSTS		U E 071 252	[1 4	0	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 071, 352	5, 071, 352		5, 082, 188	4. 00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG	204 055	303 OEO	400 100	153, 540 -102, 060	153, 540 596, 045	5. 01 5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	396, 055 609, 159	302, 050 295, 923			853, 602	5. 02
5. 04 00590 OTHER ADMIN AND GENERAL	1, 037, 444	1, 932, 475			2, 963, 771	5. 04
7. 00 00700 OPERATION OF PLANT	272, 946	887, 017			1, 159, 963	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	272, 740	007,017	1, 137, 700		60, 439	8. 00
9. 00 00900 HOUSEKEEPI NG	371, 321	111, 327			422, 209	9. 00
10. 00 01000 DI ETARY	326, 295	307, 550			84, 490	10. 00
11. 00 01100 CAFETERI A	0	0	(307, 409	11. 00
13.00 01300 NURSING ADMINISTRATION	456, 574	21, 328	477, 902		477, 902	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	45, 912	483, 429		-474, 553	54, 788	14. 00
15. 00 01500 PHARMACY	260, 110	1, 085, 027			354, 298	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	168, 929	46, 261	215, 190	o	215, 190	16. 00
17.00 01700 SOCIAL SERVICE	122, 793	13, 945	136, 738	3 o	136, 738	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	289, 356	56, 558	345, 914	22, 136	368, 050	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 013, 948	577, 325	1, 591, 273	8 0	1, 591, 273	30. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	726, 751	1, 167, 116			1, 893, 867	50. 00
53. 00 05300 ANESTHESI OLOGY	0	35, 850			35, 850	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	680, 414	762, 381	1, 442, 795		1, 442, 795	54.00
60. 00 06000 LABORATORY	758, 817	575, 470 0			1, 334, 287	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0 591, 222	171, 525	762, 747	-	0 762, 747	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	763, 478	79, 041	842, 519		842, 519	66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	703, 470	79,041	042, 513	50, 855	50, 855	71. 00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		423, 698	423, 698	72.00
PATIENTS	٥	J	· ·	120, 070	120, 070	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		990, 839	990, 839	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2, 121, 780	674, 299	2, 796, 079	-209	2, 795, 870	88. 00
88.01 08801 RURAL HEALTH CLINIC II	1, 022, 274	499, 860			1, 522, 134	88. 01
88.02 08802 RURAL HEALTH CLINIC III	362, 077	54, 151	416, 228		416, 228	88. 02
91. 00 09100 EMERGENCY	1, 241, 078	2, 179, 175	3, 420, 253	0	3, 420, 253	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY	1, 058, 917	320, 042	1, 378, 959	9 0	1, 378, 959	101. 00
SPECIAL PURPOSE COST CENTERS	245 047	100 440	F2/ 25/		F2/ 2F0	11/ 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	345, 817	190, 442			536, 259 35, 697, 030	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	15, 043, 467	20, 765, 074	35, 808, 54	-111, 511	35, 697, 030	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	0			0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	257, 874	51, 649			309, 523	
194. 00 07950 HOMEBOUND MEALS	237, 074	31, 049 N	309, 323		144, 483	
194. 01 07951 FITNESS WELLNESS PROGRAM	144, 857	19, 978			131, 863	
194. 02 07952 FOUNDATI ON	59, 030	2, 537	61, 567		61, 567	
194. 03 07953 MOWEAQUA THERAPY	139, 297	24, 511	163, 808		163, 808	
200.00 TOTAL (SUM OF LINES 118 through 199)	15, 644, 525	20, 863, 749			36, 508, 274	
					•	

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/22/2024 9:54 am

			5/22/2024 9:5	<u>4 am</u>
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	0			1.00
1.01 O0101 CAP REL COSTS-BLDG & FIXT NEW BDG EX	-246, 781	863, 185		1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-11, 696	759, 304		2. 00
3.00 00300 OTHER CAP REL COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-624, 753	4, 457, 435		4.00
5. 01 00540 NONPATI ENT TELEPHONES	-8, 182	145, 358		5. 01
5. 02 00550 DATA PROCESSING	0	596, 045		5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	853, 602		5. 03
5.04 00590 OTHER ADMIN AND GENERAL	-797, 906			5. 04
7.00 00700 OPERATION OF PLANT	-4, 629			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0			8. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY			l	10.00
11. 00 01100 CAFETERI A	-73, 838	,		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-73,030			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14. 00
	· ·			
15. 00 01500 PHARMACY	-31, 419			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-7, 981		l control of the cont	16.00
17. 00 01700 SOCIAL SERVICE	0			17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	368, 050		19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4// 072	1 124 400		20.00
	-466, 873	1, 124, 400		30. 00
ANCILLARY SERVICE COST CENTERS	757 100	1 10/ /70		
50. 00 05000 OPERATING ROOM	-757, 189		l control of the cont	50.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			54.00
60. 00 06000 LABORATORY	-6, 686			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	1	l .	64. 00
65. 00 06500 RESPIRATORY THERAPY	-56, 670		l control of the cont	65.00
66. 00 06600 PHYSI CAL THERAPY	-3, 500			66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		l .	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	0	423, 698		72. 00
PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	000 020		73. 00
OUTPATIENT SERVICE COST CENTERS	U	990, 839		/3.00
88. 00 08800 RURAL HEALTH CLINIC	-25, 695	2, 770, 175		88. 00
88. 01 08801 RURAL HEALTH CLINIC I	-23, 043			88. 01
88. 02 08802 RURAL HEALTH CLINIC III		416, 228		88. 02
91. 00 09100 EMERGENCY			l control of the cont	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-1, 071, 331	2, 348, 922		91.00
				92.00
OTHER REIMBURSABLE COST CENTERS		1 270 050		101 00
101. 00 10100 HOME HEALTH AGENCY	0	1, 378, 959		101. 00
SPECIAL PURPOSE COST CENTERS	1 070	F20 127		11/ 00
116. 00 11600 HOSPI CE	1, 878			116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-4, 193, 251	31, 503, 779		118. 00
NONREI MBURSABLE COST CENTERS		1		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		l .	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		l .	192.00
194. 00 07950 HOMEBOUND MEALS	0			194. 00
194. 01 07951 FLITNESS WELLNESS PROGRAM	0	131, 863		194. 01
194. 02 07952 FOUNDATI ON	0	,		194. 02
194. 03 07953 MOWEAQUA THERAPY	4 100 051	163, 808		194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-4, 193, 251	32, 315, 023		200. 00

Health Financial Systems PANA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 14-1341 Period: From 01/01/2023 From 01/01/2023 Pata/Time Propagation

					To 12/31/202	Date/Time Prepared: 5/22/2024 9:54 am
		Increases			<u> </u>	97 227 2021 71 01 0111
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - DIETARY COSTS					
1.00	CAFETERI A	11. 00	158, 250	149, 159		1.00
2.00	OTHER ADMIN AND GENERAL	5. 04	50, 173	47, 290		2. 00
3.00	HOMEBOUND MEALS	194. 00	74, 378	70, 105		3.00
	0		282, 801	266, 554		
	B - CRNAS					
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	22, 136		1.00
	0		0	22, 136		
	C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	101, 345		1.00
	0			101, 345		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	60, 439		1.00
				60, 439		
	E - TELEPHONE EXPENSES					
1.00	NONPATIENT TELEPHONES	5. 01	51, 480	102, 060		1.00
2.00		0.00	O	0		2.00
	0 — — — — —		51, 480	102, 060		
	F - EMPLOYEE BENEFIT PORTION	OF WELLNESS	·			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28, 976	3, 996		1. 00
	TOTALS		28, 976	3, 996		
	G - RHC PHYSICIAN RECRUITMENT					
1.00	RURAL HEALTH CLINIC	88.00	0	2, 266		1.00
				2, 266		
	I - DEPRECIATION BLDG EXPANSI	ON	<u>'</u>			
1.00	CAP REL COSTS-BLDG & FIXT	1. 01	0	826, 382		1. 00
	NEW BDG EX			•		
				826, 382		
	J - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	990, 839		1. 00
				990, 839		
	K - MEDICAL SUPPLY & IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	50, 855		1. 00
	PATI ENT					
2.00	IMPLANTABLE DEVICES CHARGED	72.00	o	423, 698		2. 00
	TO PATIENTS					
	0			474, 553		
	M - BUILDING LEASE COSTS		<u> </u>			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 475		1. 00
	TOTALS			2, 475		

Peri od: From 01/01/2023

						To 12/31/2023	Date/Time Prepared: 5/22/2024 9:54 am
		Decreases		_			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	.	
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DIETARY COSTS						
1.00	DI ETARY	10.00	282, 801	266, 554		0	1.00
2.00		0.00	0	0)	0	2. 00
3.00		0.00	0	0)	o	3.00
			282, 801	266, 554		7	
	B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	22, 136		0	1.00
				22, 136		7	
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5. 04	0	101, 345		0	1.00
			0	101, 345		7	
	D - LAUNDRY						
1.00	HOUSEKEEPI NG	9.00	0	60, 439		0	1.00
				60, 439		7	
	E - TELEPHONE EXPENSES	•					
1.00	DATA PROCESSING	5. 02		102, 060		0	1.00
2.00	CASHI ERI NG/ACCOUNTS	5. 03	51, 480			o	2. 00
	RECEI VABLE						
	0		51, 480	102, 060			
	F - EMPLOYEE BENEFIT PORTION OF	WELLNESS					
1.00	FITNESS WELLNESS PROGRAM	194. 01	28, 976	3, 996		0	1.00
	TOTALS		28, 976	3, 996			
	G - RHC PHYSICIAN RECRUITMENT						
1.00	OTHER ADMIN AND GENERAL	5. 04	0	2, 266		0	1.00
	0		0	2, 266	,		
	I - DEPRECIATION BLDG EXPANSION						
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	<u>826, 3</u> 82		9	1.00
	0		0	826, 382			
	J - DRUG COSTS						
1.00	PHARMACY	1500	0	990, 839		ol	1.00
	0		0	990, 839			
	K - MEDICAL SUPPLY & IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	474, 553		0	1.00
2.00		0.00	0	0		O	2.00
	0		0	474, 553			
	M - BUILDING LEASE COSTS						
1.00	RURAL HEALTH CLINIC	88. 00	0	<u>2, 4</u> 75		<u> </u>	1.00
	TOTALS		0	2, 475			
500 00	Grand Total: Decreases		363, 257	2, 853, 045		1	500.00

					To 12/31/2023	Date/Time Pre 5/22/2024 9:5	pared:
				Acqui si ti ons		3/22/2024 9.3	4 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	51, 361	80, 360		80, 360	0	1. 00
2.00	Land Improvements	3, 017, 777	34, 702	(34, 702	205, 969	2. 00
3.00	Buildings and Fixtures	31, 503, 247	1, 667, 719	(1, 667, 719	341, 209	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fi xed Equi pment	929, 759	1, 479, 275	(1, 479, 275	312, 727	5. 00
6. 00	Movable Equipment	7, 781, 003	563, 953	(563, 953	1, 417, 452	
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	43, 283, 147	3, 826, 009	(3, 826, 009	2, 277, 357	8. 00
9.00	Reconciling Items	-2, 127, 879	2, 070, 633	(2, 070, 633	0	9. 00
10.00	Total (line 8 minus line 9)	45, 411, 026	1, 755, 376	(1, 755, 376	2, 277, 357	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	131, 721	0				1.00
2.00	Land Improvements	2, 846, 510	0				2. 00
3.00	Buildings and Fixtures	32, 829, 757	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	2, 096, 307	0				5. 00
6.00	Movable Equipment	6, 927, 504	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	44, 831, 799	0				8. 00
9.00	Reconciling Items	-57, 246	0				9. 00
10. 00	Total (line 8 minus line 9)	44, 889, 045	0				10. 00

Health Financial Systems	PANA COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		From 01/01/2023	Worksheet A-7 Part II Date/Time Pre 5/22/2024 9:5/	pared:
			JMMARY OF CAP	· · · · -		diii
Cost Center Description	Denreciation	Lasca	Interest	Incuranca (cool	Tavas (saa	

1.01 CAP REL COSTS-BLDG & FIXT NEW BDG EX 0 0 246, 781 0 0 1.0					'	0 12/01/2020	5/22/2024 9: 5	
Instructions Instructions				SU	JMMARY OF CAPIT	AL		
Instructions Instructions						1		
9.00 10.00 11.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 862, 034 0 0 0 0 1.00 1.01 CAP REL COSTS-BLDG & FIXT NEW BDG EX 0 0 246, 781 0 0 1.00		Cost Center Description	Depreciation	Lease	Interest	,	,	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 1,862,034 0 0 0 0 1.0 1.01 CAP REL COSTS-BLDG & FIXT NEW BDG EX 0 0 246,781 0 0 1.0			9. 00	10. 00	11. 00	12.00	13. 00	
1.01 CAP REL COSTS-BLDG & FIXT NEW BDG EX 0 246, 781 0 1.0		PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
	1.00	CAP REL COSTS-BLDG & FLXT	1, 862, 034	0	0	0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 690, 844 52, 844 11, 652 0 0 2.0	1.01	CAP REL COSTS-BLDG & FLXT NEW BDG EX	0	0	246, 781	0	0	1. 01
	2.00	CAP REL COSTS-MVBLE EQUIP	690, 844	52, 844	11, 652	0	0	2.00
3.00 Total (sum of lines 1-2) 2,552,878 52,844 258,433 0 0 3.0	3.00	Total (sum of lines 1-2)	2, 552, 878	52, 844	258, 433	0	0	3.00
SUMMARY OF CAPITAL			SUMMARY 0	F CAPITAL				
Cost Center Description Other Total (1) (sum		Cost Center Description	Other	Total (1) (sum				
Capital-Relate of cols. 9			Capi tal -Relate	of cols. 9				
d Costs (see through 14)			d Costs (see	through 14)				
instructions)			instructions)					
14. 00 15. 00			14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2		PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1. 00 CAP REL COSTS-BLDG & FIXT 0 1, 862, 034 1. 0	1.00	CAP REL COSTS-BLDG & FLXT	0	1, 862, 034				1. 00
1. 01 CAP REL COSTS-BLDG & FLXT NEW BDG EX 0 246, 781 1. 0	1.01	CAP REL COSTS-BLDG & FLXT NEW BDG EX	0	246, 781				1. 01
	2.00	CAP REL COSTS-MVBLE EQUIP	0					2. 00
			0					3. 00

Heal th	Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 To 12/31/2023	5/22/2024 9: 54	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	21, 623, 886				48, 882	1.00
1.01	CAP REL COSTS-BLDG & FLXT NEW BDG EX	16, 280, 409		16, 280, 40		36, 803	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	6, 927, 504		6, 927, 50		15, 660	2.00
3.00	Total (sum of lines 1-2)	44, 831, 799		44, 831, 79			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		_				
1.00	CAP REL COSTS-BLDG & FLXT	0	0	10,00		2, 475	1.00
1.01	CAP REL COSTS-BLDG & FLXT NEW BDG EX	0	0	36, 80		0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	15, 66			2.00
3. 00	Total (sum of lines 1-2)	U		101, 34 JMMARY OF CAPI		55, 319	3. 00
				JIMIMARY OF CAPI			
	Cost Center Description		Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	DART LLL DESCRIPTION OF CARLEY COOTS OF	11.00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		10.000			1 007 000	4 00
1.00	CAP REL COSTS BLDG & FLXT	0	.0,002		0	1, 087, 009	1.00
1. 01	CAP REL COSTS MADE FOUND	0	36, 803		0	863, 185	1. 01
2.00 3.00	CAP REL COSTS-MVBLE EQUIP	0	15, 660		0 0	759, 304	2. 00 3. 00
3.00	Total (sum of lines 1-2)	0	101, 345	l '	0	2, 709, 498	3.00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

Cost Center Description Seal S/Code (2) Amount To/From and ch the Anount is to be Adjusted					T	o 12/31/2023	Date/Time Prep 5/22/2024 9:54	pared:
Doc Center Description Brsis/Code (2) Aesumt								T GIII
1.00 Investment Income - CAR RTI Chapter 2					10/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAR STI CODE 2.00 3.00 4.00 5.00 1.00								
1.00 Investment Income - CAR STI CODE 2.00 3.00 4.00 5.00 1.00								
Investment income - CAP REL OSCA-PREL COSTS-BLDG & FIXT 1.00 0 1.00		Cost Center Description						
1.01 Investment Income - CAP REL S	1. 00	II.	1.00					1. 00
COSTS-BLIG & FIXT NEW BOC EX NeW BOC EX Chapter 1 (Income C. DP REL 11,652 CAP REL COSTS-MVBLE EQUIP 2,00 11 2,00 10 10 10 10 10 10 10	1. 01		В	-246, 781	CAP REL COSTS-BLDG & FIXT	1. 01	11	1. 01
Investment income - CAP REL 8		II.		•				
Investment Income - other	2.00		В	-11, 652	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
Chapter 2	3 00			0		0.00		3 00
1 discounts (chapter 8) 0 discounts (discounts 6) 0 discounts		(chapter 2)		· ·				
Second S	4. 00			0		0.00	0	4. 00
Comparison Com	5. 00	Refunds and rebates of		0		0. 00	О	5. 00
Taicephone services (pay stations excluded) Taicephone services (pay stations excluded) Chapter 21)	6. 00			0		0.00	О	6. 00
Stations excluded) (Chapter 21) 21) 210 21) 210	7 00			0		0.00	0	7 00
1 10 1 10 1 10 10 10	7.00	stations excluded) (chapter		J		0.00		7. 00
Parking Int (chapter 21) 0 0.00 0.	8. 00		А	-4, 629	OPERATION OF PLANT	7. 00	0	8. 00
10.00 Provider-based physician A-B-2 -2,356,871 0 10.00 odd od	0.00					0.00	0	0.00
11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization A-8-1 0 0 12.00 13.00 14.00 13.00 14.00 15.			A-8-2	-2, 356, 871		0.00	_	
(chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and Il nen service 0 14.00 Caffeter ia-employees and guests B -73,725 CAFETERIA 11.00 0 14.00 14.00 Caffeter ia-employees and guests B -73,725 CAFETERIA 11.00 0 14.00 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of fugs to other than patients 18.00 Sale of drugs to other than patients 19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 20.00 Vending machines 21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Income from imposition of interest expense on Medicare overpayments and borrowings to therest expense on Medicare overpayments and borrowings to the coverpayments and borrowings to physicians's compensation (Chapter 14) 24.00 Adjustment for physical therapy costs in excess of I limitation (chapter 14) 25.00 Utilization revel we physicians's compensation (CoSTS-BLDG & FIXT CoCTS-BLDG & F	11 00			0		0.00	0	11 00
Transactions (chapter 10)		(chapter 23)		-		0.00		
14.00 Cafeteria-employees and guests B -73,725CAFETERIA 11.00 0.14.00 0.50 0.50 0.	12. 00		A-8-1	O			0	12. 00
15.00 Rental of quarters to employee 0 0.00			D	72 725	CAFETERIA		0	
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 0 17.00 0 0 17.00 0 0 0 0 0 0 0 0 0				-73, 725 0	CAPETERIA		0	
Supplies to other than patients	16 00			0		0.00	0	16 00
17. 00 Sale of drugs to other than plant ents 0 0 0 0 17. 00 18. 00 0 0 0 18. 00 18. 00 0 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0		supplies to other than		J		0.00		10.00
18.00 Sale of medical records and abstracts 16.00 0 18.00 18.00 18.00 19.00	17. 00			0		0.00	0	17. 00
abstracts Nursing and allied health education (fulition, fees, books, etc.)	18 00		R	_7 981	MEDICAL RECORDS & LIBRARY	16 00	0	18 00
Education (tuition, fees, books, etc.) 20.00 Vending machines B		abstracts		7, 701	WEDTONE REGORDS & ETBRAKT			
20.00 Vending machines B -113 CAFETERIA 11.00 0 20.00	19. 00			O		0.00	0	19. 00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 1 1 1 1 1 1 1 1 1	20.00		D	110	CAFETERIA	11 00		20.00
Charges (chapter 21) Case Chapter 21) Case		Income from imposition of	Ь	-113	CAPETERIA			
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments A-8-3 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 26.01 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 0 NONPHYSICIAN ANESTHETISTS 19.00 22.00 22.00 22.00 23.00 24.00 24.00 24.00 25.00 25.00 26.00 26.00 27.00 26.00 27.00 28.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 21) 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 24) 20.00 Adjustment for occupational therapy costs in excess of limitation (chapter 24) 20.00 CAP REL COSTS-MVBLE EQUIP (COSTS-MVBLE EQUIP) 2								
repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	22. 00	Interest expense on Medicare		0		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT								
I imitation (chapter 14) Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
therapy costs in excess of i mit tation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL (COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT NEW BDG EX COSTS-BLDG & FIXT NEW BDG EX COSTS-BLDG & FIXT NEW BDG EX COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP		limitation (chapter 14)			DUNGLOAL TUEDADY			0.4.00
25. 00 Utilization review -	24. 00		A-8-3	Ü	PHYSICAL THERAPY	66.00		24. 00
physicians' compensation (chapter 21)	25 00			0	*** Cost Cantar Dalated ***	114 00		25 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 26. 01 Depreciation - CAP REL COSTS-BLDG & FIXT 1.01 0 26. 01 26. 01 Depreciation - CAP REL COSTS-BLDG & FIXT 1.01 0 26. 01 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.01 0 26. 01 NEW BDG EX 0 0 0 27. 00 28. 00 Non-physician Anesthetist 0 0 0 28. 00 29. 00 Physicians' assistant 0 0 0 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of A-8-3 0 **** Cost Center Deleted **** 67. 00 30. 00	23.00	physicians' compensation		O	cost center bereteu	114.00		23.00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT NEW BDG EX 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS ONONPHYSICIAN ANESTHETISTS ONONPHYSICIAN AND COSTS-MVBLE EQUIP Adjustment for occupational therapy costs in excess of	26. 00			0	CAP REL COSTS-BLDG & FLXT	1. 00) ()	26. 00
COSTS-BLDG & FIXT NEW BDG EX Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS ON Adjustment for occupational therapy costs in excess of NEW BDG EX OCAP REL COSTS-MVBLE EQUIP ONONPHYSICIAN ANESTHETISTS ON NONPHYSICIAN ANESTHETISTS ON NONPHYSICIAN ANESTHETISTS ON NONPHYSICIAN ANESTHETISTS ON NONPHYSICIAN ANESTHETISTS ON O		COSTS-BLDG & FLXT						
COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 0 0 0 0 0 29. 00 30. 00 *** Cost Center Deleted *** 67. 00 30. 00		COSTS-BLDG & FLXT NEW BDG EX			NEW BDG EX			
28. 00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19. 00 29. 00 29. 00 Adjustment for occupational therapy costs in excess of A-8-3 0 *** Cost Center Deleted *** 67. 00 30. 00	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of A-8-3 0 *** Cost Center Deleted *** 67.00 30.00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS		_ ا	
therapy costs in excess of			A-8-3	0	*** Cost Center Deleted ***			
		therapy costs in excess of						
30. 99 Hospice (non-distinct) (see A -1, 878 ADULTS & PEDIATRICS 30. 00 30. 99	30. 99	Hospice (non-distinct) (see	А	-1, 878	ADULTS & PEDIATRICS	30.00		30. 99
instructions)		instructions)	1					

				To	12/31/2023	Date/Time Prep 5/22/2024 9:54	pared: 4 am
				Expense Classification on	Worksheet A	072272021 7.0	T Calli
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	,	1.00	2.00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	MI SCELLANEOUS I NCOME	В	·	OTHER ADMIN AND GENERAL	5. 04	0	33. 00
33. 01	MI SCELLANEOUS I NCOME	В	-25, 695	RURAL HEALTH CLINIC	88. 00	0	33. 01
34.00	SPORTS MEDICINE INCOME	В	-3, 500	PHYSI CAL THERAPY	66.00	0	34. 00
35.00	ADVERTI SI NG	A	-61, 598	OTHER ADMIN AND GENERAL	5. 04	0	35. 00
36.00	PATIENT PHONE COSTS - CAPITAL	A	-44	CAP REL COSTS-MVBLE EQUIP	2. 00	9	36. 00
36. 01	PATIENT PHONE COSTS - BENEFITS	A	-938	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	36. 01
36. 02	PATIENT PHONE COSTS - SALARY	A	-3, 290	NONPATIENT TELEPHONES	5. 01	0	36. 02
36. 03	PATIENT PHONE COSTS - OTHER	A	-4, 892	NONPATIENT TELEPHONES	5. 01	0	36. 03
38. 00	SELF-INS CASH PMNTS TO	A	-611, 224	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	38. 00
	HOSPI TAL						
39. 00	PHYSICIAN RECRUITMENT	A		OTHER ADMIN AND GENERAL	5. 04	0	39. 00
40.00	HOSPI CE COSTS	A	,	HOSPI CE	116. 00	0	40. 00
41.00	LOBBYI NG	A	·	OTHER ADMIN AND GENERAL	5. 04	0	41.00
44.00	MEDICALD TAX	A	-676, 292	OTHER ADMIN AND GENERAL	5. 04	0	44. 00
45.00	GOODWILL AMORTIZATION	A	·	OTHER ADMIN AND GENERAL	5. 04	0	45. 00
45. 01	PHYSICIAN BENEFITS - HOSP &	A	-12, 591	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 01
	PODI ATRY						
45. 02	340B RETAIL PHARMACY COSTS	A		PHARMACY	15. 00	0	45. 02
45. 03	RHC NON-ALLOWABLE CONTRACT	A	0	RURAL HEALTH CLINIC	88. 00	0	45. 03
	PHYSICIAN						
50.00	TOTAL (sum of lines 1 thru 49)		-4, 193, 251				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			ONC D L 45 4			

- (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.

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

2. 00 65. 00 RESPI RATORY THERAPY 56, 670 56, 670 0 0 0 2 3. 00 91. 00 EMERGENCY 2, 004, 459 1, 071, 331 933, 128 0 0 3 4. 00 50. 00 OPERATI NG ROOM 757, 189 757, 189 0 0 0 4 5. 00 30. 00 ADULTS & PEDI ATRI CS 464, 995 464, 995 0 0 0 0 0 6. 00 0. 00 0 0 0 0 0 0 0 0 7. 00 0. 00 0 0 0 0 0 0 0 0 0 8. 00 0. 00 0 0 0 0 0 0 0 0	m
1.00 2.00 3.00 4.00 5.00 6.00 7.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 60.00 LABORATORY 36,000 6,686 29,314 0 0 1 2.00 65.00 RESPI RATORY THERAPY 56,670 56,670 0 0 0 2 3.00 91.00 EMERGENCY 2,004,459 1,071,331 933,128 0 0 3 4.00 50.00 OPERATI NG ROOM 757,189 757,189 0	
1. 00 60. 00 LABORATORY 36, 000 6, 686 29, 314 0 0 1 2. 00 65. 00 RESPI RATORY THERAPY 56, 670 56, 670 0 0 0 2 3. 00 91. 00 EMERGENCY 2, 004, 459 1, 071, 331 933, 128 0 0 0 3 4. 00 50. 00 OPERATI NG ROOM 757, 189 757, 189 0 0 0 0 0 5. 00 30. 00 ADULTS & PEDI ATRI CS 464, 995 464, 995 0 <td></td>	
2. 00 65. 00 RESPI RATORY THERAPY 56, 670 56, 670 0 0 0 2 3. 00 91. 00 EMERGENCY 2, 004, 459 1, 071, 331 933, 128 0 0 3 4. 00 50. 00 OPERATI NG ROOM 757, 189 757, 189 0 0 0 4 5. 00 30. 00 ADULTS & PEDI ATRI CS 464, 995 464, 995 0 0 0 0 0 6. 00 0. 00 0 0 0 0 0 0 0 0 7. 00 0. 00 0 0 0 0 0 0 0 0 0 8. 00 0. 00 0 0 0 0 0 0 0 0	
3.00 91.00 EMERGENCY 2,004,459 1,071,331 933,128 0 0 3 4.00 50.00 OPERATING ROOM 757,189 757,189 0 0 0 4 5.00 30.00 ADULTS & PEDIATRICS 464,995 464,995 0 0 0 5 6.00 0.00 0 0 0 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 0 0 0 0 8.00 0.00 0	1.00
4.00 50.00 OPERATING ROOM 757, 189 757, 189 0 0 0 4 5.00 30.00 ADULTS & PEDIATRICS 464, 995 464, 995 0<	2. 00
5.00 30.00 ADULTS & PEDIATRICS 464,995 464,995 0 0 0 0 5 6.00 0.00 0<	3. 00
6.00 0.00 7.00 0.00 8.00 0.00	1. 00
7. 00	5. 00
8.00 0.00 0 0 0 8	5. 00
	7. 00
	3. 00
9.00 0.00 0 0 0 0 0 0 9	9. 00
	0. 00
200.00 3, 319, 313 2, 356, 871 962, 442 0 200	
Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provider Physician Cost	
Identifier Limit Unadjusted RCE Memberships & Component of Malpractice	
Limit Continuing Share of col. Insurance	
Education 12	
1.00 2.00 8.00 9.00 12.00 13.00 14.00	
1.00 60.00 LABORATORY 0 0 0 0 0 1	1.00
2.00 65.00 RESPI RATORY THERAPY 0 0 0 0 0 0 2	2. 00
3.00 91.00 MERGENCY 0 0 0 0 3	3. 00
4.00 50.00 OPERATING ROOM 0 0 0 0 0 4	1. 00
5.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 5	5. 00
6.00 0.00 0 0 0 0 6	5. 00
	7. 00
8.00 0.00 0 0 0 0 8	3. 00
	9. 00
	0. 00
200.00	
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustment	
Identifier Component Limit Disallowance	
Share of col.	
1.00 2.00 15.00 16.00 17.00 18.00	
1. 00 60. 00 LABORATORY 0 0 0 6, 686 1	1. 00
2. 00 65. 00 RESPI RATORY THERAPY 0 0 0 56, 670 2	2. 00
3.00 91.00 MERGENCY 0 0 1,071,331 3	3. 00
4.00 50.00 OPERATING ROOM 0 0 757, 189 4	1. 00
5.00 30.00 ADULTS & PEDIATRICS 0 0 0 464,995 5	5. 00
6.00 0.00 0 0 0 6	5. 00
7.00 0.00 0 0 0 7	7. 00
8.00 0.00 0 0 0 8	3. 00
9.00 0.00 0 0 0 9	9. 00
10.00 0.00 0 0 0 0 10	0. 00
200. 00 0 0 2, 356, 871 200	0. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part/Time Propagate Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1341

COST Center Description					To	12/31/2023	Date/Time Pre	pared:
COST CENTER DESCRIPTION Not Expenses For Cost All Death of (From Mar.) REMPLOYEE BIMELTS DEPARTMENT				CAPI	TAL RELATED CO	STS	5/22/2024 9:5	4 am
CEMPRAL SERVICE COST CENTERS								
Al Location CFMPBAL SERVICE COST CENTERS 0 1.00 1.01 2.00 4.00 1.01		Cost Center Description		BLDG & FIXT		MVBLE EQUIP		
CFRORM SERVICE COST CENTERS					NEW BUG EX			
SEMERAL SERVICE COST CENTERS 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.087,009 1.088,000 1.087,009							DEI / IKTIMEIVT	
SENDRAL SERVICE COST CENTERS 1,087,009 1,087,009 1,087,009 1,087,009 1,001								
1.00		CENEDAL SEDVICE COST CENTEDS	0	1. 00	1. 01	2. 00	4.00	
1.01 0.0101 CAP REL COSTS-BLDG & FIXT NEW BDG EX 50,3185 0 863,185 0 759,304 2 0 0 0 0 0 0 0 4,47,435 4.00 0.040 0.050	1. 00		1, 087, 009	1, 087, 009				1.00
4.00 0.0400 EMPLOYEE BENEFITS DEPARTMENT								l
	2.00		759, 304			759, 304		2. 00
5.02 OSSO DATA PROCESSING 596, 045 22,540 4,182 47,914 115,615 5.02				-	0	-		•
5.03 OSSQ\ CASHIERI NG/ACCOUNTS RECEI VABLE 853,002 35,864 0 4.299 162,795 5.04 7.00 00700\ OPTREA MAIN AND GENERAL 2.165,865 135,452 46,773 12.251 317,493 5.04 7.00 00700\ OPTREA MAIN AND GENERAL 2.165,865 135,452 46,773 12.251 317,493 5.04 7.00 00700\ OPTREA MAIN AND GENERAL 2.165,865 32,401 3.10,270 7.658 79,777 7.00 0			1		4 192			•
5,04 00590 OTHER ADMIN AND GENERAL 2,165,865 135,452 46,773 12,251 317,493 5,04			1					1
7.00 00700 OPERATI ON OF PLANT 1.155, 334 327,763 310, 270 17, 658 79, 677 7. 08 9.00 00900 LAUNDRY & LINEN SERVICE 60, 439 0 10.00 10.00 0 0 13.2 0 0 46.00 0 0 0 13.3 201 10.00 13.00 13.3 0 0 13.3 0 13.3 0 13.3 0 13.3 0 13.3 0 13.3 0 13.3 0 13.3 0 13.3 0 15.00 0 0 0 13.3 0 15.00 0 0 0 0 2.9,789 0 28,888 75.930 0 15.00 <td></td> <td></td> <td>1</td> <td></td> <td>- 1</td> <td></td> <td></td> <td>1</td>			1		- 1			1
9.00 00900 HOUSEKEEPING 422, 209 15, 365 2, 491 3, 309 108, 395 9, 00. 01 0.00 1000 DIETARY 84, 490 16, 071 50, 926 9, 302 12, 697 10, 00 11.00 01100 CAFETERIA 233, 571 0 31, 202 0 46, 196 11, 200 11.00 01100 CAFETERIA 313, 00 100 NURSING ADMINISTRATION 477, 902 2, 713 0 0 0 0 133, 281 13, 300 118.00 113.00 1130 0130 0130 0133, 281 13, 300 118.00 118.00 01400 CENTRAL SERVICES & SUPPLY 54, 788 1, 290 29, 778 0 131, 402 14, 00 115.00 01500 PHARMACY 322, 579 7, 589 0 28, 585 75, 930 15, 00 170.00 01500 MEDICAL RECORDS & LIBRARY 207, 209 7, 458 0 11, 411 49, 313 16, 00 170.00 01700 MEDICAL RECORDS & LIBRARY 207, 209 7, 458 0 1, 411 49, 313 16, 00 170.00 01700 MEDICAL SERVICE 3136, 738 2, 616 0 391 35, 845 17, 00 170.00 01700 MEDICAL SERVICE COST CENTERS 368, 050 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	00700 OPERATION OF PLANT						1
10.00 01000 01ETARY		1	1	- 1	0	ĭ		1
11.00 01100 CAFTERIA 233,571 0 31,202 0 46,196 11.00 1.00		1	1					ı
13.00 01300 NURSING ADMINISTRATION 477, 902 2, 713 0 0 133, 281 13.00			1					•
14. 00 01400 CENTRAL SERVICES & SUPPLY 54, 788 1, 290 29, 778 0 13, 402 14, 00			1	-		-	•	•
16.00 01600 MEDICAL RECORDS & LIBRARY 207, 209 7, 458 0 1, 411 49, 313 16.00 17.00 1700 SOCIAL SERVICE 136, 738 2, 616 0 391 35, 845 17.00 19.00			1			o		•
17. 00	15.00	01500 PHARMACY	322, 879	7, 859	0	28, 858	75, 930	15. 00
19.00			1					1
INPATIENT ROUTI NE SERVICE COST CENTERS 1,124,400 81,230 0 28,688 291,769 30.00 20.00			1					1
30.00	19.00		368, 050	U	[U	······································	0	19.00
SO	30. 00		1, 124, 400	81, 230	0	28, 688	291, 769	30.00
53.00 05300 0540								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 442, 795 23, 553 49, 443 260, 353 198, 624 54. 00 60. 00 00 00 00 0 0 0 0 0				-	264, 801		200, 810	•
60. 00 06000 LABORATORY 1, 327, 601 4, 319 47, 485 52, 304 221, 511 60. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 64. 00 65. 00 6500 RESPI RATORY THERAPY 706, 077 31, 399 25, 834 26, 395 172, 587 65. 00 66. 00 66600 PHYSI CAL THERAPY 839, 019 112, 970 0 22, 860 222, 871 66. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 50, 855 0 0 0 0 0 0 0 71. 00 72. 00 PATI ENTS 700 07200 IMPLANTABLE DEVI CES CHARGED TO 423, 698 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 990, 839 0 0 0 0 0 0 0 0 0				-	10 113		100 624	•
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64.00 65.00 66.								1
66. 00 06600 PHYSI CAL THERAPY 839, 019 112, 970 0 22, 860 222, 871 66. 00 71. 00 71. 00 0 0 0 0 0 0 0 0 0								l
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 50, 855 0 0 0 0 0 0 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 423, 698 0 0 0 0 0 0 72. 00 PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 990, 839 0 0 0 0 0 0 0 73. 00 000 000 0 0 0 0 0 0			1					1
72. 00			1					•
PATIENTS			1	-	-	-		•
73. 00 07300 DRUGS CHARGED TO PATIENTS 990, 839 0 0 0 0 0 0 0 0 0	72.00		423, 090	U	U	o o	U	72.00
88. 00	73.00		990, 839	0	0	0	0	73. 00
88. 01 08801 RURAL HEALTH CLINIC III 1,522,134 28,626 0 0 0 298,418 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 416,228 15,535 0 4,286 105,696 88. 02 91. 00 09100 EMERGENCY 2,348,922 47,227 0 25,748 362,291 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 10100 HOME HEALTH AGENCY 1,378,959 47,495 0 25,518 309, 115 101. 00 11600 HOME HEALTH AGENCY 538,137 0 0 5,518 309, 115 101. 00 116. 00 11600 HOSPI CE 538,137 0 0 0 6,990 100,950 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 31,503,779 1,024,064 863,185 756,981 4,268,722 118. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 94. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 309,523 55,658 0 0 0 75,278 192. 00 194. 00 107951 FI TNESS WELLNESS PROGRAM 131,863 0 0 0 1,746 33,828 194. 01								
88. 02								1
91. 00						-	•	•
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART								1
101. 00 10100 HOME HEALTH AGENCY 1, 378, 959 47, 495 0 25, 518 309, 115 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 538, 137 0 0 0 6, 990 100, 950 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 503, 779 1, 024, 064 863, 185 756, 981 4, 268, 722 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 4, 489 0 0 0 19200 PHYSI CIANS' PRI VATE OFFI CES 309, 523 55, 658 0 0 0 75, 278 192. 00 194. 00 07950 HOMEBOUND MEALS 144, 483 0 0 0 0 21, 712 194. 00 194. 01 07951 FI TNESS WELLNESS PROGRAM 131, 863 0 0 0 1, 746 33, 828 194. 01	92.00			·		·	•	92. 00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE								
116. 00	101.00		1, 378, 959	47, 495	0	25, 518	309, 115	101. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 503, 779 1, 024, 064 863, 185 756, 981 4, 268, 722 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 4, 489 0 0 0 190. 00 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 309, 523 55, 658 0 0 0 75, 278 192. 00 194. 00 07950 HOMEBOUND MEALS 144, 483 0 0 0 0 21, 712 194. 00 194. 01 07951 FI TNESS WELLNESS PROGRAM 131, 863 0 0 0 1, 746 33, 828 194. 01	116 00		539 137	0	O	6 000	100 050	116 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 4,489 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 309,523 55,658 0 0 0 75,278 192.00 194.00 07950 HOMEBOUND MEALS 144,483 0 0 0 0 21,712 194.00 194.01 07951 FI TNESS WELLNESS PROGRAM 131,863 0 0 1,746 33,828 194.01								
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 309, 523 55, 658 0 0 75, 278 192. 00 194.00 07950 HOMEBOUND MEALS 144, 483 0 0 0 21, 712 194. 00 194.01 07951 FI TNESS WELLNESS PROGRAM 131, 863 0 0 1, 746 33, 828 194. 01			0.70007777	1, 02 1, 00 1	0007.00	700,701	1,200,722	
194. 00 07950 HOMEBOUND MEALS 144, 483 0 0 0 21, 712 194. 00 194. 01 07951 FI TNESS WELLNESS PROGRAM 131, 863 0 0 1, 746 33, 828 194. 01			1			-		
194. 01 07951 FI TNESS WELLNESS PROGRAM 131, 863 0 0 1, 746 33, 828 194. 01			1			O		
				0	· ·	1 7/4		
32 3.732 3.333 31			1	0 2 7 08		1, 746		
194. 03 07953 MOWEAQUA THERAPY 163, 808 0 0 577 40, 663 194. 03				2, 7, 70	ol	577		1
200.00 Cross Foot Adjustments 200.00	200.00	Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers 0 0 0 201.00		1 1 9		0	0	0		
202.00 TOTAL (sum lines 118 through 201) 32,315,023 1,087,009 863,185 759,304 4,457,435 202.00	202. 00		32, 315, 023	1, 087, 009	863, 185	759, 304	4, 457, 435	J202. 00

Provider CCN: 14-1341

			lo	12/31/2023	Date/lime Pre 5/22/2024 9:5	
Cost Center Description	NONPATI ENT	DATA	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN	+ aiii
oost denter beserretten	TELEPHONES	PROCESSI NG	OUNTS	Subtotui	AND GENERAL	
			RECEI VABLE		71110 0211211112	
	5. 01	5. 02	5. 03	5A. 03	5. 04	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FLXT NEW BDG EX						1. 01
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 NONPATI ENT TELEPHONES	161, 390					5. 01
5. 02 00550 DATA PROCESSING	21, 843	809, 139				5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	11, 528	60, 331	1, 128, 419			5. 03
5. 04 00590 OTHER ADMIN AND GENERAL	10, 314	42, 586		2, 730, 734	2, 730, 734	5. 04
7. 00 00700 OPERATION OF PLANT	1, 820	10, 647	0	1, 903, 169	175, 670	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 020	10, 047	Ö	60, 439	5, 579	8. 00
9. 00 00900 HOUSEKEEPI NG	607	3, 549	- 1	555, 925	51, 314	9. 00
10. 00 01000 DI ETARY	1, 820	7, 098		182, 404	16, 837	10. 00
11. 00 01100 CAFETERI A	1, 020	7,090		310, 969	28, 704	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 820	10, 647		626, 363	57, 816	13. 00
		•				
14. 00 01400 CENTRAL SERVICES & SUPPLY	607	3, 549	0	103, 414	9, 546	14. 00
15. 00 01500 PHARMACY	1, 820	14, 195	0	451, 541	41, 679	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	3, 034	14, 195		282, 620	26, 087	16.00
17. 00 01700 SOCI AL SERVI CE	1, 213	7, 098	- 1	183, 901	16, 975	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	368, 050	33, 972	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	40.055	04.040	0.4.054	4 500 005	447 (74	00.00
30.00 O3000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	13, 955	24, 842	34, 951	1, 599, 835	147, 671	30. 00
50. 00 05000 OPERATING ROOM	3, 640	35, 489	113, 076	1, 909, 202	176, 227	50. 00
53. 00 05300 OPERATTING ROOM 53. 00 05300 ANESTHESI OLOGY	607	7, 098				53. 00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY 05400 RADI OLOGY DI AGNOSTI C		7, 098 42, 586		88, 945	8, 210 215, 811	
	6, 067			2, 338, 050		54. 00
	6, 067 0	35, 489		1, 899, 405	175, 323	60.00
64. 00 06400 I NTRAVENOUS THERAPY	9	0	0	1 054 4/1	07.221	64. 00
65. 00 06500 RESPI RATORY THERAPY	7, 281	31, 940		1, 054, 461	97, 331	65. 00
66. 00 06600 PHYSI CAL THERAPY	9, 101	42, 586		1, 314, 615	121, 344	66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		58, 316	5, 383	71. 00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0	9, 599	433, 297	39, 995	72. 00
PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	o	0	87, 815	1, 078, 654	99, 564	73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	07,015	1, 076, 054	77, 304	73.00
88. 00 08800 RURAL HEALTH CLINIC	20, 022	102, 915	48, 537	3, 620, 446	334, 169	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	9, 708	92, 270		1, 968, 196	181, 672	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	3, 640	24, 842		578, 535	53, 401	88. 02
91. 00 09100 EMERGENCY	8, 494	39, 037		2, 951, 508	272, 436	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 474	37, 037	117, 707	2, 931, 300	272, 430	92. 00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
101. 00 10100 HOME HEALTH AGENCY	9, 101	46, 135	0	1, 816, 323	167, 654	101 00
SPECIAL PURPOSE COST CENTERS	7, 101	40, 133		1,010,020	107, 034	101.00
116. 00 11600 HOSPI CE	0	78, 075	0	724, 152	66, 842	116 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	154, 109	777, 199		31, 193, 469	2, 627, 212	
NONREI MBURSABLE COST CENTERS	.017.07	,,,,,,,	17 7	0.17.1707.1071	2,02,72.12	
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	4, 489	414	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	4, 854	17, 744	- 1	468, 573	43, 251	
194. 00 07950 HOMEBOUND MEALS	n	0	0	166, 195	15, 340	194, 00
194. 01 07951 FITNESS WELLNESS PROGRAM	1, 213	7, 098	-	175, 748	16, 222	
194. 02 07952 FOUNDATION	607	3, 549		85, 753		194. 02
194. 03 07953 MOWEAQUA THERAPY	607	3, 549		220, 796	20, 380	
200.00 Cross Foot Adjustments	507	5, 547	11,072	220, 770		200. 00
201.00 Negative Cost Centers	n	0	0	ol O		201. 00
202.00 TOTAL (sum lines 118 through 201)	161, 390	809, 139		32, 315, 023		
	101,070	307, 107	1 ., 120, 117	02, 010, 020	2, 700, 704	_02.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1341

				10	12/31/2023	Date/lime Pre 5/22/2024 9:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	4 aiii
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9.00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00101 CAP REL COSTS-BLDG & FLXT NEW BDG EX						1. 01
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00540 NONPATI ENT TELEPHONES						5. 01
	00550 DATA PROCESSING						5. 02
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
	00590 OTHER ADMIN AND GENERAL						5. 04
	00700 OPERATION OF PLANT	2, 078, 839					7. 00
	00800 LAUNDRY & LINEN SERVICE	0	66, 018	l l			8. 00
	00900 HOUSEKEEPI NG	44, 301	0				9. 00
	01000 DI ETARY	99, 915	0		332, 167	005 700	10.00
	01100 CAFETERI A	34, 599	0	,	0	385, 703	11.00
	01300 NURSI NG ADMI NI STRATI ON	7, 334	0	_,	0	11, 341	13.00
	01400 CENTRAL SERVICES & SUPPLY	36, 506	0	,	0	4, 383	14.00
	01500 PHARMACY	21, 246	0	.,	0	8, 129	15.00
	01600 MEDI CAL RECORDS & LI BRARY	20, 161	0	-,	0	10, 136	16.00
	01700 SOCIAL SERVICE	7, 071	0	-,	0	6, 257	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	3, 547	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	210 505	10 202	72 552	222 1/7	20.042	20.00
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	219, 595	18, 383	72, 553	332, 167	38, 942	30. 00
	05000 OPERATING ROOM	293, 627	8, 048	97, 012	0	31, 247	50.00
	05300 ANESTHESI OLOGY	293, 627	8,048		0	31, 247	53.00
	05400 RADI OLOGY-DI AGNOSTI C	118, 497	7, 888	· ·	0	33, 523	54.00
	06000 LABORATORY	64, 330	7,000		0	32, 886	
	06400 I NTRAVENOUS THERAPY	04, 330			0	32, 880	64.00
	06500 RESPIRATORY THERAPY	113, 531	433	· ·	0	28, 570	
	06600 PHYSI CAL THERAPY	305, 399		100, 903	0	32, 384	66.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	303, 377	3,307		0	32, 304	71. 00
	07200 IMPLANTABLE DEVICES CHARGED TO		٥		0	0	72.00
72.00	PATIENTS			J	Ĭ	Ü	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	-	-		-1		
	08800 RURAL HEALTH CLINIC	147, 110	0	48, 604	0	63, 430	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	77, 386	6	25, 568	o	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	41, 998	0	0	o	0	88. 02
91. 00	09100 EMERGENCY	127, 673	21, 395	42, 182	О	49, 848	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS				·		
	10100 HOME HEALTH AGENCY	128, 396	0	35, 641	0	12, 311	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	_		0	•	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 908, 675	59, 520	595, 319	332, 167	370, 280	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	12, 136			0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	150, 464	0		0		192. 00
	07950 HOMEBOUND MEALS	0	0	-	0		194. 00
	07951 FITNESS WELLNESS PROGRAM	0	4, 848		0	12, 010	
	07952 FOUNDATION	7, 564	0	2, 499	0		194. 02
	07953 MOWEAQUA THERAPY	0	1, 650	0	0	0	194. 03
200.00	Cross Foot Adjustments		_			^	200. 00
201.00	Negative Cost Centers	2 070 020	4, 010	V = 1 = 40	222 1/7		201. 00
202. 00	TOTAL (sum lines 118 through 201)	2, 078, 839	66, 018	651, 540	332, 167	385, 703	J2U2. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1341

				10	12/31/2023	5/22/2024 9:5	
Cost Center Des	scription	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	i diii
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14.00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST	CENTERS						
1.00 00100 CAP REL COSTS-E	BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-E	BLDG & FIXT NEW BDG EX						1. 01
2.00 00200 CAP REL COSTS-N	NVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFI	TS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELE	EPHONES						5. 01
5. 02 00550 DATA PROCESSI NO							5. 02
5. 03 00580 CASHI ERI NG/ACCO	OUNTS RECEIVABLE						5. 03
5. 04 00590 OTHER ADMIN AND) GENERAL						5. 04
7.00 00700 OPERATION OF PL	_ANT						7. 00
8.00 00800 LAUNDRY & LINEN	N SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINIS	STRATI ON	705, 277					13. 00
14. 00 01400 CENTRAL SERVI CE		0	165, 910				14. 00
15. 00 01500 PHARMACY		21, 206	365				15. 00
16. 00 01600 MEDI CAL RECORDS	S & LIBRARY	0	3, 976	· ·	349, 641		16. 00
17. 00 01700 SOCIAL SERVICE	5 a 2.5.0	16, 322	2	Ö	017,011	232, 864	17. 00
19. 00 01900 NONPHYSI CI AN AN	NESTHETI STS	9, 252	0	Ö	o	0	19. 00
I NPATI ENT ROUTI NE SEI		7,202		<u> </u>	<u> </u>		
30. 00 03000 ADULTS & PEDI AT		101, 589	26, 169	0	11, 276	186, 291	30.00
ANCILLARY SERVICE COS		, , , , , ,			, -,		
50. 00 05000 OPERATI NG ROOM		81, 515	24, 544	0	36, 481	0	50.00
53. 00 05300 ANESTHESI OLOGY		0	7, 349	0	8, 814	0	53. 00
54. 00 05400 RADI OLOGY-DI AGN	NOSTIC	87, 453	4, 317	0	101, 537	0	54.00
60. 00 06000 LABORATORY		85, 791	3, 238	0	66, 018	0	60.00
64.00 06400 INTRAVENOUS THE	ERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THE	ERAPY	74, 533	5, 264	0	17, 082	0	65. 00
66. 00 06600 PHYSI CAL THERAF	Рγ	84, 482	1, 080	0	21, 037	0	66. 00
71.00 07100 MEDICAL SUPPLIE	ES CHARGED TO PATIENT	0	0	0	2, 407	0	71. 00
72.00 07200 I MPLANTABLE DEV		o	0	0	3, 097	0	72. 00
PATI ENTS							
73. 00 07300 DRUGS CHARGED 1		0	0	551, 185	28, 331	0	73. 00
OUTPATIENT SERVICE CO							
88. 00 08800 RURAL HEALTH CL		0	13, 678	0	0	0	88. 00
88. 01 08801 RURAL HEALTH CL		0	4, 177	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CL	_INIC III	0	968		0	0	88. 02
91.00 09100 EMERGENCY		130, 043	62, 408	0	38, 646	46, 573	91.00
92.00 09200 OBSERVATION BED	OS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE CO							
101. 00 10100 HOME HEALTH AGE		0	6, 801	0	7, 096	0	101. 00
SPECIAL PURPOSE COST	CENTERS						
116. 00 11600 HOSPI CE	05 111150 4 11 1 147	0	273		4, 079		116. 00
	OF LINES 1 through 117)	692, 186	164, 609	551, 185	345, 901	232, 864	1118.00
NONREI MBURSABLE COST			0		ما	0	100.00
190. 00 19000 GLFT, FLOWER, (0	0		0		190.00
192. 00 19200 PHYSI CI ANS' PRI			837	0	0		192. 00
194. 00 07950 HOMEBOUND MEALS		0	0		0		194. 00
194. 01 07951 FI TNESS WELLNES	SS PKUGKAM	0	464	0	0		194. 01
194. 02 07952 FOUNDATION		0	0	0	0		194. 02
194. 03 07953 MOWEAQUA THERAF		13, 091	0	0	3, 740	0	194. 03
200.00 Cross Foot Adju			0			_	200.00
201.00 Negative Cost (705 277	145 010	0	240 641		201. 00
202.00 TOTAL (sum line	es 118 through 201)	705, 277	165, 910	551, 185	349, 641	232, 864	1202. UU

Health Financial Systems	PANA COMMUNIT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				rom 01/01/2023	Part I	
				o 12/31/2023	Date/Time Pre 5/22/2024 9:5	
Cost Center Description	NONPHYSI CI AN	Subtotal	Intern &	Total	3/22/2024 9.5	4 alli
cost center bescription	ANESTHETI STS	Subtotal	Residents Cost			
	ANLSTILLITSIS		& Post			
			Stepdown			
			· ·			
	19. 00	24.00	Adjustments	24 00		
CENEDAL SEDVICE COST CENTERS	19.00	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS			T			1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT NEW BDG EX						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSI NG						5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5. 04 00590 OTHER ADMIN AND GENERAL						5. 04
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						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
19. 00 01900 NONPHYSICIAN ANESTHETISTS	414, 821					19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	2, 754, 471	-48, 597	2, 705, 874		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 657, 903	s	2, 657, 903		50. 00
53. 00 05300 ANESTHESI OLOGY	414, 821	528, 139		528, 139		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 946, 226		2, 946, 226		54.00
60. 00 06000 LABORATORY	o	2, 348, 245	sl c	2, 348, 245		60.00
64.00 06400 INTRAVENOUS THERAPY	ol	0				64.00
65. 00 06500 RESPIRATORY THERAPY	o	1, 428, 715				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 984, 611	1			66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		66, 106	1	66, 106		71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	0	476, 389				72.00
PATIENTS		470, 307	1	470, 307		/2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	1, 757, 734		1, 757, 734		73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	1, 757, 754		1, 757, 754		73.00
88. 00 08800 RURAL HEALTH CLINIC	ol	4, 227, 437	· C	4, 227, 437		88. 00
88. 01 08801 RURAL HEALTH CLINIC 1			1			1
	- I	2, 257, 005	1			88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	674, 902	1			88. 02
91. 00 09100 EMERGENCY	0	3, 742, 712	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 00
OTHER REIMBURSABLE COST CENTERS			_			1
101.00 10100 HOME HEALTH AGENCY	0	2, 174, 222	2 (2, 174, 222		101. 00
SPECIAL PURPOSE COST CENTERS						4
116. 00 11600 HOSPI CE		798, 692				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	414, 821	30, 823, 509		30, 823, 509		118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	21, 049		21, 049		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	712, 837	'	712, 837		192.00
194.00 07950 HOMEBOUND MEALS	l ol	181, 535	i c	181, 535		194. 00
194.01 07951 FITNESS WELLNESS PROGRAM	0	209, 292				194. 01
194. 02 07952 FOUNDATI ON	ام	107, 144		107, 144		194. 02
194. 03 07953 MOWEAQUA THERAPY	ار	259, 657				194. 03
200.00 Cross Foot Adjustments	الم	207, 007				200. 00
201.00 Negative Cost Centers		0				201.00
202.00 TOTAL (sum lines 118 through 201)	111 021	22 21E 022	1			201.00
202.00 TOTAL (Suil TITIES TTO LITEOUGH 201)	414, 821	32, 315, 023	'I	32, 315, 023		1202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1341

				To	12/31/2023	Date/Time Pre 5/22/2024 9:5	
			CAPI	TAL RELATED CO	STS	372272024 7.3	4 alli
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	Subtotal	
		Assigned New Capital		NEW BDG EX			
		Related Costs					
		0	1.00	1. 01	2. 00	2A	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0101 CAP REL COSTS-BLDG & FLXT NEW BDG EX						1. 01
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	2. 00 4. 00
	0540 NONPATIENT TELEPHONES	0	1, 302	-	663	1, 965	
	0550 DATA PROCESSING	0	23, 540		47, 914	75, 636	5. 02
5. 03 00	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	825	35, 864	0	4, 299	40, 988	5. 03
	0590 OTHER ADMIN AND GENERAL	1, 640	135, 452	46, 773	12, 251	196, 116	
1	0700 OPERATION OF PLANT	1, 800	327, 763		17, 658	657, 491	7. 00
	0800 LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
4	0900 N. ETARY	0	15, 365		3, 309	21, 165	9.00
	000 DI ETARY 100 CAFETERI A	0	16, 071 0		9, 302 0	76, 299 31, 202	1
	300 NURSING ADMINISTRATION	0	2, 713		0	2, 713	1
4	400 CENTRAL SERVICES & SUPPLY	i o	1, 290		o	31, 068	1
	500 PHARMACY	1, 256	7, 859		28, 858	37, 973	1
16. 00 01	600 MEDICAL RECORDS & LIBRARY	0	7, 458	0	1, 411	8, 869	16. 00
	700 SOCIAL SERVICE	0	2, 616		391	3, 007	17. 00
	900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	IPATIENT ROUTINE SERVICE COST CENTERS SOOO ADULTS & PEDIATRICS	O	81, 230	0	28, 688	109, 918	30.00
	ICILLARY SERVICE COST CENTERS	ı o	61, 230	0	20, 000	107, 710	30.00
	5000 OPERATING ROOM	89, 467	0	264, 801	154, 708	508, 976	50.00
	300 ANESTHESI OLOGY	1, 382	0		18, 069	19, 451	53. 00
	8400 RADI OLOGY-DI AGNOSTI C	0	23, 553	49, 443	260, 353	333, 349	54. 00
	0000 LABORATORY	0	4, 319		52, 304	104, 108	1
	0400 I NTRAVENOUS THERAPY	0	0	١	0	0	64. 00
	500 RESPI RATORY THERAPY 5600 PHYSI CAL THERAPY	5, 254	31, 399 112, 970		26, 395 22, 860	88, 882 135, 830	65. 00 66. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	112, 970	1	22, 800	135, 830	71.00
	2200 IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	0	72.00
	PATIENTS			_			
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	TPATIENT SERVICE COST CENTERS	1					
	8800 RURAL HEALTH CLINIC	12,000	54, 417		5, 006	59, 423	
	8801 RURAL HEALTH CLINIC II 8802 RURAL HEALTH CLINIC III	12,000	28, 626 15, 535		0 4, 286	40, 626 19, 821	88. 01 88. 02
	2100 EMERGENCY	0	47, 227		25, 748	72, 975	1
	2200 OBSERVATION BEDS (NON-DISTINCT PART		77,227	Ĭ	25, 740	72, 773	
	THER REIMBURSABLE COST CENTERS						
	0100 HOME HEALTH AGENCY	9, 400	47, 495	0	25, 518	82, 413	101. 00
	PECIAL PURPOSE COST CENTERS			,			
	600 HOSPI CE	4, 442		"	6, 990		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) WREI MBURSABLE COST CENTERS	127, 466	1, 024, 064	863, 185	756, 981	2, 771, 696	1118.00
	2000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	l ol	4, 489	0	ol	4 480	190. 00
1	2200 PHYSICIANS' PRIVATE OFFICES		55, 658		0		192. 00
	7950 HOMEBOUND MEALS		0		ő		194. 00
	7951 FITNESS WELLNESS PROGRAM	0	O	0	1, 746		194. 01
	7952 FOUNDATI ON	0	2, 798	0	О		194. 02
	'953 MOWEAQUA THERAPY	12, 987	0	0	577	13, 564	
200.00	Cross Foot Adjustments		_				200.00
201.00	Negative Cost Centers	140 453	1 007 000	042 105	750 204		201. 00
202.00	TOTAL (sum lines 118 through 201)	140, 453	1, 087, 009	863, 185	759, 304	2, 849, 951	J2U2. UU

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1341

				1	o 12/31/2023	Date/lime Pre 5/22/2024 9:5	
	Cost Center Description	EMPLOYEE	NONPATI ENT	DATA	CASHI ERI NG/ACC		T GIII
	, , , , , , , , , , , , , , , , , , ,	BENEFITS	TELEPHONES	PROCESSI NG	OUNTS	AND GENERAL	
		DEPARTMENT			RECEI VABLE		
		4. 00	5. 01	5. 02	5. 03	5. 04	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT NEW BDG EX						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4 0/5				4. 00
5. 01	00540 NONPATI ENT TELEPHONES	0	1, 965				5. 01
5. 02	00550 DATA PROCESSING	0	268				5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	140			000 007	5. 03
5. 04	00590 OTHER ADMIN AND GENERAL	0	126			200, 237	5. 04
7.00	00700 OPERATION OF PLANT	0	22			12, 881	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0			409	8. 00
9.00	00900 HOUSEKEEPI NG	0	7	333		3, 763	9.00
10.00	01000 DI ETARY	U	22	666		1, 235	10.00
11. 00	01100 CAFETERI A	0	0			2, 105	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	22			4, 239	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	U	7	333		700	14.00
15. 00	01500 PHARMACY	0	22			3, 056	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	37	1, 332		1, 913	16.00
17. 00	01700 SOCI AL SERVI CE	0	15			1, 245	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	2, 491	19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		170	2 220	1 440	10,000	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	170	2, 330	1, 449	10, 828	30. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	O	4.4	2 220	4 (00	12 021	FO 00
50. 00 53. 00	05300 ANESTHESI OLOGY	0	44	· ·		12, 921	50.00
	05400 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	U	7	666		602	53. 00
54. 00		0	74			15, 824	54. 00
60.00	06000 LABORATORY	U	74			12, 855	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0			7 127	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	89			7, 137	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	111	· ·		8, 897	66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			395	71. 00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO	U	0	0	398	2, 933	72. 00
73. 00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0	2 4 4 1	7, 300	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	l ol	0		3, 641	7, 300	/3.00
88. 00	08800 RURAL HEALTH CLINIC	O	244	9, 652	2, 012	24, 512	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		118			13, 321	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	44			3, 916	88. 02
91. 00	09100 EMERGENCY	0	103			19, 976	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	103	3,002	4, 700	17, 770	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	ol	111	4, 328	0	12, 293	101 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		4, 320	<u> </u>	12, 273	101.00
116 00	11600 HOSPI CE	O	0	7, 324	0	4 901	116. 00
118.00			1, 877			192, 648	
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	1,077	12, 701	40,070	172, 040	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	ol	0	0	0	30	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		59				192. 00
	07950 HOMEBOUND MEALS		0				194. 00
	07951 FITNESS WELLNESS PROGRAM		15	_	-		194. 00
	07952 FOUNDATION		7				194. 01
	07953 MOWEAQUA THERAPY		7	333			194. 02
200.00			,	333	401		200. 00
201.00		٥	0	0	0		200.00
201.00		0	1, 965				
202.00	1 1017L (Sum 111103 110 till bugit 201)	ı Y	1, 703	1 13, 904	40, 700	200, 237	1202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1341

				10	12/31/2023	5/22/2024 9:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	T GIII
	2001 3011101 20001 pt. 011	PLANT	LINEN SERVICE	11000EREEL 1110	5.2	07.11 2.7.2.7.7.	
		7. 00	8. 00	9.00	10.00	11. 00	
GENE	RAL SERVICE COST CENTERS						
1.00 0010	O CAP REL COSTS-BLDG & FIXT						1.00
1.01 0010	11 CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00 0020	O CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 0040	O EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 0054	O NONPATI ENT TELEPHONES						5. 01
	O DATA PROCESSING						5. 02
	O CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
	O OTHER ADMIN AND GENERAL						5. 04
	O OPERATION OF PLANT	671, 393					7. 00
	O LAUNDRY & LINEN SERVICE	0	409				8.00
	O HOUSEKEEPI NG	14, 308	0				9. 00
	O DI ETARY	32, 269	Ö		112, 496		10.00
1	O CAFETERI A	11, 174	0		0	45, 175	1
4	O NURSING ADMINISTRATION	2, 369	Ö		0	1, 328	1
4	O CENTRAL SERVICES & SUPPLY	11, 790	0		Ö	513	1
	O PHARMACY	6, 862	0		o o	952	
	O MEDICAL RECORDS & LIBRARY	6, 511	0		o	1, 187	
	O SOCIAL SERVICE	2, 284	0		0	733	1
	O NONPHYSICIAN ANESTHETISTS	2, 204	0		o	415	
	TIENT ROUTINE SERVICE COST CENTERS		0	U	<u> </u>	413	19.00
	O ADULTS & PEDIATRICS	70, 922	114	4, 407	112, 496	4, 561	30. 00
	LLARY SERVICE COST CENTERS	10, 922	114	4, 407	112, 490	4, 301	30.00
	O OPERATING ROOM	94, 831	50	5, 893	0	3, 660	50.00
	O ANESTHESI OLOGY	•			1	•	1
		0	0 49		0	0	
	O RADI OLOGY-DI AGNOSTI C	38, 270			-	3, 926	
	LABORATORY	20, 776	0		0	3, 852	
	O I NTRAVENOUS THERAPY	0	0		0	0	64. 00
	O RESPI RATORY THERAPY	36, 666	3	' '	0	3, 346	
	O PHYSI CAL THERAPY	98, 635	21	6, 129	0	3, 793	1
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	
72. 00 0720	O IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	0	72. 00
	PATI ENTS						
	O DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	ATIENT SERVICE COST CENTERS	Г		T			1
1	O RURAL HEALTH CLINIC	47, 511	0		0	7, 430	1
	1 RURAL HEALTH CLINIC II	24, 993	0	,	0	0	
	2 RURAL HEALTH CLINIC III	13, 564	0	_	0	0	88. 02
	O EMERGENCY	41, 234	132	2, 562	0	5, 838	1
	O OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	R REIMBURSABLE COST CENTERS						
	O HOME HEALTH AGENCY	41, 467	0	2, 165	0	1, 442	101. 00
	I AL PURPOSE COST CENTERS						1
116. 00 1160	l .	0	-		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	616, 436	369	36, 160	112, 496	43, 368	118. 00
	EI MBURSABLE COST CENTERS						1
	O GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3, 919	0		0		190. 00
	O PHYSICIANS' PRIVATE OFFICES	48, 595	0		0		192. 00
	O HOMEBOUND MEALS	0	0	0	0	0	194. 00
194. 01 0795	1 FITNESS WELLNESS PROGRAM	0	30	0	0	1, 407	194. 01
194. 02 0795	2 FOUNDATION	2, 443	0	152	0	400	194. 02
194. 03 0795	3 MOWEAQUA THERAPY	0	10	0	0	0	194. 03
200.00	Cross Foot Adjustments				1		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	671, 393	409	39, 576	112, 496	45, 175	
		•	•				-

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1341

				Ic	12/31/2023	Date/lime Pre 5/22/2024 9:5	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	5551 551161 B5551 Ft. 511	ADMI NI STRATI ON	SERVICES &		RECORDS &	0001712 021111 02	
			SUPPLY		LI BRARY		
		13.00	14. 00	15.00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00101 CAP REL COSTS-BLDG & FLXT NEW BDG EX						1. 01
1	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4	00540 NONPATIENT TELEPHONES						5. 01
1	00550 DATA PROCESSING						5. 02
1	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
	00590 OTHER ADMIN AND GENERAL						5. 04
	00700 OPERATION OF PLANT						7. 00
1	00800 LAUNDRY & LINEN SERVICE						8. 00
1	00900 HOUSEKEEPI NG						9. 00
1	01000 DI ETARY						10.00
1	01100 CAFETERI A	44.04					11.00
	01300 NURSI NG ADMINI STRATI ON	11, 817					13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	45, 144				14. 00
	D1500 PHARMACY	355	99		04 007		15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	1, 082		21, 336		16.00
1	01700 SOCIAL SERVICE	273	I	0	0	8, 366	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	155	0	0	0	0	19. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	1 700	7 101		/ 0.7	/ /02	20.00
-	03000 ADULTS & PEDIATRICS	1, 702	7, 121	0	687	6, 693	30.00
	ANCILLARY SERVICE COST CENTERS	1 2//	/ /70		2 222	0	FO 00
4	05000 OPERATING ROOM	1, 366	6, 678		2, 223		50.00
	D5300 ANESTHESI OLOGY D5400 RADI OLOGY-DI AGNOSTI C	1 4/5	2,000		537	0	53. 00 54. 00
	06000 LABORATORY	1, 465 1, 437	1, 175 881	0	6, 218 4, 022	0	60.00
1		1,437	0 0	· -	4, 022	0	64.00
1	D6400 I NTRAVENOUS THERAPY D6500 RESPI RATORY THERAPY	1 240	-	· -	_	0	65.00
		1, 249	1, 432 294		1, 041	0	66.00
	06600 PHYSI CAL THERAPY	1, 416	294		1, 282 147	0	71.00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT D7200 IMPLANTABLE DEVICES CHARGED TO		0		189		71.00
72.00	PATIENTS	١	U	U	109	U	72.00
73. 00	D7300 DRUGS CHARGED TO PATIENTS		0	51, 077	1, 726	0	73. 00
-	OUTPATIENT SERVICE COST CENTERS	<u> </u>		31,077	1, 720	0	73.00
	D8800 RURAL HEALTH CLINIC	0	3, 722	0	0	0	88. 00
	D8801 RURAL HEALTH CLINIC II		1, 136		0	0	88. 01
	08802 RURAL HEALTH CLINIC III		263		0	0	88. 02
	09100 EMERGENCY	2, 180	16, 981	0	2, 355		1
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,100	.0, 70.	Ĭ	2,000	., 0, 0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	1, 851	0	432	0	101. 00
	SPECIAL PURPOSE COST CENTERS	-1	.,	-			
	11600 HOSPI CE	0	74	0	249	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11, 598	44, 790		21, 108		118. 00
i i	NONREI MBURSABLE COST CENTERS	, , , , ,			,	.,	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		228		0		192. 00
	07950 HOMEBOUND MEALS	o	0		0		194. 00
	07951 FITNESS WELLNESS PROGRAM	o	126	0	0		194. 01
	07952 FOUNDATION	0	0		0		194. 02
	07953 MOWEAQUA THERAPY	219	0	0	228		194. 03
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)	11, 817	45, 144	51, 077	21, 336	8, 366	202. 00
	•	. '				-	-

Health Financial Systems	PANA COMMUNIT	Y HUSPITAL		in Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part II Date/Time Pre 5/22/2024 9:5	pared:
Cost Center Description	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown	Total		
	19. 00	24. 00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	19.00	24.00	25.00	20.00		
1. 00						1.00 1.01 2.00 4.00 5.01 5.02 5.03 5.04 7.00 8.00 9.00 10.00 11.00 13.00
14. 00	3, 061					14. 00 15. 00 16. 00 17. 00 19. 00
30. 00 03000 ADULTS & PEDIATRICS		333, 398	0	333, 398		30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06400 LABORATORY 64. 00 06400 RADI RAVENUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 IMPLANTABLE DEVI CES CHARGED TO PATI ENTS PATI ENTS		644, 659 24, 396 419, 773 161, 109 0 147, 314 263, 106 851 3, 520	0 0 0	644, 659 24, 396 419, 773 161, 109 0 147, 314 263, 106 851 3, 520		50.00 53.00 54.00 60.00 64.00 65.00 66.00 71.00 72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		63, 744	0	63, 744		73. 00
OUTPATIENT SERVICE COST CENTERS		157, 458 91, 109 40, 282 174, 637	0 0			88. 00 88. 01 88. 02 91. 00 92. 00
101. 00 10100 HOME HEALTH AGENCY		146, 502	! 0	146, 502		101.00
SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	24, 372 2, 696, 230	0	24, 372		116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 HOMEBOUND MEALS 194. 01 07951 FITNESS WELLNESS PROGRAM 194. 02 07952 FOUNDATION 194. 03 07953 MOWEAQUA THERAPY 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 TOTAL (sum lines 118 through 201)	3, 061 0 3, 061	8, 682 112, 625 1, 125 5, 179 6, 713 16, 336 3, 061 0 2, 849, 951	0 0 0	5, 179 6, 713 16, 336 3, 061		190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00 202. 00

		cial Systems	PANA COMMUNI I			In Lie	u of Form CMS-	
COST A	ILLOCAT	ION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2023 o 12/31/2023		pared:
			CADI	TAL RELATED CO	nete		5/22/2024 9:5	4 am
		Cost Center Description	BLDG & FIXT	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
		Sost sonter beserver on	(SQUARE FEET)	NEW BDG EX	(DOLLAR VALUE)	BENEFITS	TELEPHONES	
				(SQUARE FEET)		DEPARTMENT	(# OF PHONE S)	
						(GROSS SALARI ES)		
	OENES.	AL OFFICE COOT OFFITTED	1.00	1. 01	2.00	4. 00	5. 01	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	89, 351					1.00
1. 01	1	CAP REL COSTS-BLDG & FIXT NEW BDG EX	07, 331	29, 103				1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			743, 644			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0 107	0	0	15, 269, 607	2//	4.00
5. 01 5. 02		NONPATI ENT TELEPHONES DATA PROCESSI NG	1, 935	141	649 46, 926	48, 190 396, 055	266 36	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2, 948	0	4, 210	557, 679	19	5. 03
5. 04	1	OTHER ADMIN AND GENERAL	11, 134	1, 577	1	1, 087, 617	17	5. 04
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	26, 942 0	10, 461 0	17, 294 0	272, 946 0	3	7. 00 8. 00
9. 00		HOUSEKEEPI NG	1, 263	84		371, 321	1	9. 00
10.00	1	DIETARY	1, 321	1, 717			3	
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	0 223	1, 052	0	158, 250 456, 574	0	1 00
14. 00		CENTRAL SERVICES & SUPPLY	106	1, 004		45, 912	1	14. 00
15. 00	1	PHARMACY	646	0	28, 263		3	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	613 215	0	1, 382 383	168, 929 122, 793	5 2	
		NONPHYSICIAN ANESTHETISTS	0		I		0	
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	6, 677	0	28, 096	999, 497	23	30.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	8, 928	151, 517	687, 905	6	50.00
53. 00		ANESTHESI OLOGY	0	0	17, 696	0	1	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 936	1, 667			10	
60. 00 64. 00	1	LABORATORY INTRAVENOUS THERAPY	355	1, 601	51, 225 0	758, 817 0	10	1
65. 00	1	RESPIRATORY THERAPY	2, 581	871	· ·	591, 222	12	
66. 00		PHYSI CAL THERAPY	9, 286	0	22, 389	763, 478	15	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	0	
72.00	07200	PATI ENTS				J	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	4, 473	0	4, 903	2, 121, 780	33	88. 00
88. 01		RURAL HEALTH CLINIC II	2, 353	Ö		1, 022, 274	16	1
88. 02		RURAL HEALTH CLINIC III	1, 277	0	4, 198		6	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	3, 882	0	25, 217	1, 241, 078	14	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00	10100	HOME HEALTH AGENCY	3, 904	0	24, 992	1, 058, 917	15	101. 00
116 00		AL PURPOSE COST CENTERS HOSPI CE	O	0	6, 846	345, 817	0	116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	84, 177	29, 103				118.00
	NONRE	MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	369					190.00
		PHYSICIANS' PRIVATE OFFICES HOMEBOUND MEALS	4, 575 0	0		257, 874 74, 378		192. 00 194. 00
	1	FITNESS WELLNESS PROGRAM	o	0	1		2	194. 01
		FOUNDATION	230	0	0	59, 030		194. 02
194. 03 200. 00		MOWEAQUA THERAPY Cross Foot Adjustments	0	0	565	139, 297	1	194. 03 200. 00
201.00	1	Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	1, 087, 009	863, 185	759, 304	4, 457, 435	161, 390	202. 00
203. 00		Part I) Unit cost multiplier (Wkst. B, Part I)	12. 165605	29. 659657	1. 021058	0. 291916	606. 729323	303 00
204.00	1	Cost to be allocated (per Wkst. B,	12. 103003	24. 034037	1.021038	0. 291910		204. 00
		Part II)						
205. 00)	Unit cost multiplier (Wkst. B, Part II)				0. 000000	7. 387218	205. 00
206.00)	NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1341 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Cost Center Description DATA CASHIERING/ACC Reconciliation OTHER ADMIN OPERATION OF PROCESSI NG OUNTS AND GENERAL PLANT (# OF TERMI RECEI VABLE (ACCUM. COST) (SQUARE FEET) NALS) (GROSS REVE NUE) 7. 00 5.02 5.03 5A. 04 5.04 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 CAP REL COSTS-BLDG & FIXT NEW BDG EX 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 228 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 17 75, 702, 326 5.03 5.04 00590 OTHER ADMIN AND GENERAL 12 -2, 730, 734 29, 584, 289 5.04 1, 903, 169 63, 209 00700 OPERATION OF PLANT 7.00 7 00 3 Ω 0 0 00800 LAUNDRY & LINEN SERVICE 8.00 C 0 60, 439 Λ 8.00 9.00 00900 HOUSEKEEPI NG 555, 925 1, 347 9.00 10.00 01000 DI ETARY 0 182, 404 3,038 10.00 2 0 3 310, 969 01100 CAFFTERIA 0 1, 052 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 0 626, 363 223 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 103, 414 1, 110 14.00 01500 PHARMACY 0 15 00 Ω 451 541 646 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 282, 620 613 16.00 01700 SOCIAL SERVICE 0 183, 901 17.00 17.00 215 01900 NONPHYSICIAN ANESTHETISTS 368, 050 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 7 2, 344, 775 1, 599, 835 6, 677 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10 7, 585, 969 0 1, 909, 202 8, 928 50.00 05300 ANESTHESI OLOGY 2 1, 832, 891 0 88. 945 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 12 21, 107, 670 2, 338, 050 3,603 54.00 06000 LABORATORY 10 0 1, 899, 405 60.00 13, 727, 936 1, 956 60.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 3, 552, 098 0 06500 RESPIRATORY THERAPY 1, 054, 461 65.00 3, 452 65.00 06600 PHYSI CAL THERAPY 12 4, 374, 590 0 1, 314, 615 9, 286 66.00 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 58, 316 71 00 500, 504 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 433, 297 0 643, 937 72.00 **PATIENTS** 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 891, 278 0 1,078,654 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 29 0 3, 620, 446 4, 473 88.00 88.00 3, 256, 193 08801 RURAL HEALTH CLINIC II 0 88.01 26 1, 143, 148 1, 968, 196 2, 353 88 01 88.02 08802 RURAL HEALTH CLINIC III 557, 353 0 578, 535 1, 277 88.02 91.00 09100 EMERGENCY 11 8, 036, 285 0 2, 951, 508 3, 882 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 13 0 0 1, 816, 323 3, 904 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 22 724, 152 0 116 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 219 74, 554, 627 -2, 730, 734 28, 462, 735 58, 035 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 4, 489 369 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 5 0 4, 575 192. 00 370, 058 468, 573 194.00 07950 HOMEBOUND MEALS 0 0 166, 195 0 194.00 194. 01 07951 FI TNESS WELLNESS PROGRAM 0 175, 748 0 194. 01 194. 02 07952 FOUNDATI ON 0 230 194. 02 85, 753 194. 03 07953 MOWEAQUA THERAPY 0 194. 03 777, 641 0 220, 796 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 202.00 809.139 2, 730, 734 2, 078, 839 202. 00 Cost to be allocated (per Wkst. B, 1, 128, 419 Part I) 32. 888339 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 3, 548. 855263 0.014906 0.092304 204.00 Cost to be allocated (per Wkst. B, 75, 904 46, 788 200, 237 671, 393 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 332 912281 0.000618 0.006768 10. 621794 205. 00 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1341 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS SERVED) ADMI NI STRATI ON (SQUARE FEET) (HOURS OF (POUNDS OF SERVICE) (DIRECT NRSING LAUNDRY) HR) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT NEW BDG EX 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.04 00590 OTHER ADMIN AND GENERAL 5.04 00700 OPERATION OF PLANT 7.00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 105, 284 8.00 9.00 00900 HOUSEKEEPI NG 59, 961 9.00 10.00 01000 DI ETARY 0 3, 038 4, 911 10.00 0 01100 CAFFTERIA 1, 052 239 802 11 00 11 00 C 01300 NURSING ADMINISTRATION 13.00 0 223 0 7,051 168, 084 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 1, 110 0 2,725 14.00 0 5, 054 01500 PHARMACY 15 00 0 5 054 15 00 646 16.00 01600 MEDICAL RECORDS & LIBRARY 613 0 6, 302 Λ 16.00 01700 SOCIAL SERVICE 0 0 3, 890 3,890 17.00 17.00 215 01900 NONPHYSICIAN ANESTHETISTS 2, 205 19.00 19.00 2, 205 INPATIENT ROUTINE SERVICE COST CENTERS 4, 911 30.00 03000 ADULTS & PEDIATRICS 29, 317 6, 677 24, 211 24, 211 30.00 ANCILLARY SERVICE COST CENTERS 19, 427 19, 427 50.00 05000 OPERATING ROOM 12,835 8, 928 0 50.00 05300 ANESTHESI OLOGY 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 12, 579 3,603 0 20, 842 20, 842 54.00 06000 LABORATORY 0 60.00 1, 956 20, 446 20, 446 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 0 0 0 06500 RESPIRATORY THERAPY 65.00 690 3.452 17, 763 17, 763 65.00 06600 PHYSI CAL THERAPY 5, 369 9, 286 0 20, 134 20, 134 66.00 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 72.00 **PATIENTS** 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 4, 473 0 88.00 88.00 0 39.437 0 08801 RURAL HEALTH CLINIC II 0 88.01 10 2, 353 Λ 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 0 0 88.02 91.00 09100 EMERGENCY 34, 121 3, 882 0 30, 992 30, 992 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 3, 280 0 7, 654 0 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 2 080 0 116 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 94, 921 54, 787 4, 911 230, 213 164, 964 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 369 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 4, 575 0 194.00 07950 HOMEBOUND MEALS 0 0 0 0 194.00 C 194. 01 07951 FI TNESS WELLNESS PROGRAM 0 194. 01 7,732 0 7, 467 194. 02 07952 FOUNDATI ON 0 0 194. 02 230 2, 122 194. 03 07953 MOWEAQUA THERAPY 0 3, 120 194. 03 2.631 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 66, 018 651, 540 332, 167 385, 703 705, 277 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) 4. 195979 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.627047 10.866063 67.637345 1.608423 11, 817 204. 00 204.00 Cost to be allocated (per Wkst. B, 409 39, 576 112, 496 45, 175 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.003885 0.660029 22 906944 0 188385 0. 070304 205. 00 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

				To	com 01/01/2023 0 12/31/2023	Date/Time Pre 5/22/2024 9:5	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	T dill
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	19. 00	
1.00 1.01 2.00 4.00 5.01 5.02 5.03 5.04	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT NEW BDG EX 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN AND GENERAL						1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04
8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	90, 013 198 2, 157 1	990, 839 0 0	72, 699, 177 0	100		7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	100	19. 00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	14, 198	0	2, 344, 775	80	0	30. 00
53.00	05000 OPERATING ROOM 05300 ANESTHESI OLOGY	13, 316 3, 987	0	1, 832, 891	0	0 100	1
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 342 1, 757	0	21, 107, 670 13, 727, 936	0 0	0	54. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	O	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 856 586	0	3, 552, 098 4, 374, 590	0	0	65. 00 66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPLANTABLE DEVICES CHARGED TO	0	0	4, 374, 390 500, 504 643, 937	0	0	71. 00 72. 00
	PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	0	990, 839	5, 891, 278	0	0	73. 00
	08800 RURAL HEALTH CLINIC	7, 421	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 266	0		0	0	88. 01
	08802 RURAL HEALTH CLINIC	525 33, 859	0		0 20	0	88. 02 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			., ,			92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	3, 690	0	1, 475, 474	ol	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	3,090	O	1, 475, 474	ΟĮ	0]101.00
118.00		148 89, 307	0 990, 839				116. 00 118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	0	0	ol	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	454	0		o		192. 00
	07950 HOMEBOUND MEALS	0	0	0	0		194. 00
	07951 FITNESS WELLNESS PROGRAM 07952 FOUNDATION	252	0	0	0		194. 01 194. 02
194. 03	07953 MOWEAQUA THERAPY	0	0	777, 641	ō		194. 03
200.00							200. 00 201. 00
201. 00 202. 00		165, 910	551, 185	349, 641	232, 864	414, 821	1
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	1. 843178 45, 144	0. 556281 51, 077		2, 328. 640000 8, 366	4, 148. 210000 3, 061	203. 00 204. 00
205. 00		0. 501528	0. 051549	0. 000293	83. 660000	30. 610000	205. 00
206. 00							206. 00
207. 00	1 1 7						207. 00

Health Financial Systems
POST STEPDOWN ADJUSTMENTS In Lieu of Form CMS-2552-10
Worksheet B-2 PANA COMMUNITY HOSPITAL Provider CCN: 14-1341

				3/22/2024 9.34	+ alli
		Works	sheet		
	Description	CODE Line No.		Amount	
	1. 00	2.00	3. 00	4. 00	
1.00	ADJ FOR EPO COSTS IN RENAL	1	74.00	0	1. 00
	DI ALYSI S				
2.00	ADJ FOR EPO COSTS IN HOME	1	94.00	0	2.00
	PROGRAM				
3.00	ADJ FOR ARANESP COSTS IN	1	74.00	0	3.00
	RENAL DIALYSIS				
4.00	ADJ FOR ARANESP COSTS IN	1	94.00	0	4.00
	HOME PROGRAM				
5.00	ADJ FOR ESA COSTS IN RENAL	1	74.00	0	5.00
	DI ALYSI S				
6.00	ADJ FOR ESA COSTS IN HOME	1	94.00	0	6.00
	PROGRAM				
7.00	IV THERAPY	1	30.00	-48, 597	7.00
8.00	IV THERAPY	1	64.00	48, 597	8.00

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1341	Peri od: Worksheet C
		From 01/01/2023 Part
		To 12/21/2022 Data/Time Dropared.

					To 12/31/2023	Date/Time Pre	
			Title	xVIII	Hospi tal	5/22/2024 9:5 Cost	4 am
			11 21 0	7,,,,,	Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26) 1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDIATRICS	2, 705, 874		2, 705, 87	4 0	0	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	2, 703, 074		2, 703, 07	4 0	0	30.00
50.00	05000 OPERATI NG ROOM	2, 657, 903		2, 657, 90	3 0	0	50.00
53. 00	05300 ANESTHESI OLOGY	528, 139	•	528, 13		l o	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 946, 226		2, 946, 22		0	54.00
60.00	06000 LABORATORY	2, 348, 245		2, 348, 24		0	1
64.00	06400 I NTRAVENOUS THERAPY	48, 597		48, 59	7 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	1, 428, 715	0	1, 428, 71	5 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 984, 611	0	1, 984, 61	1 0	0	66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 106		66, 10	6 0	0	71.00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	476, 389		476, 389	9 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 757, 734		1, 757, 73	4 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	4, 227, 437		4, 227, 43	7 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 257, 005		2, 257, 00	5 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	674, 902		674, 90	2 0	0	88. 02
91.00	09100 EMERGENCY	3, 742, 712		3, 742, 71	2 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	157, 325		157, 32	5	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2, 174, 222		2, 174, 22	2	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	798, 692		798, 69:			116. 00
200.00	,	30, 980, 834	0	30, 980, 83			200. 00
201.00	I I	157, 325		157, 32			201. 00
202.00	Total (see instructions)	30, 823, 509	0	30, 823, 50	9 0	0	202. 00

Health Financial Systems	PANA COMMUNI	TY HOSPI TAL			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der 0	CCN: 14-1341	F	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepar 5/22/2024 9:54 a		
		Ti tl	e XVIII		Hospi tal	Cost	
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (co	ol. 6	Cost or Other	TEFRA	

						5/22/2024 9:54	4 am
		_	Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		1, 796, 386		1, 796, 386			30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00		11, 247	7, 339, 677			0.000000	
53.00		16, 034	1, 761, 887			0.000000	
54.00	1	414, 056	20, 321, 215			0.000000	
60.00		522, 890	13, 001, 777	13, 524, 667		0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	11, 958	407, 018	418, 976	0. 115990	0.000000	64. 00
65.00		1, 126, 306	2, 390, 109	3, 516, 415	0. 406299	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	971, 569	3, 340, 948	4, 312, 517	0. 460198	0.000000	66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 531	350, 340	482, 871	0. 136902	0.000000	71. 00
72.00		0	628, 936	628, 936	0. 757452	0.000000	72.00
	PATI ENTS						
73. 00		807, 947	5, 031, 565	5, 839, 512	0. 301007	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	3, 256, 193	3, 256, 193	3		88. 00
88. 01		0	1, 143, 148	1, 143, 148	3		88. 01
88. 02		0	557, 353				88. 02
91. 00		50, 012	7, 893, 307			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 040	119, 831	121, 871	1. 290914	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	O 10100 HOME HEALTH AGENCY	0	1, 475, 474	1, 475, 474	!		101. 00
	SPECIAL PURPOSE COST CENTERS						
	0 11600 H0SPI CE	0	848, 129				116. 00
200.00		5, 862, 976	69, 866, 907	75, 729, 883	3		200. 00
201.00	1						201. 00
202.00	O Total (see instructions)	5, 862, 976	69, 866, 907	75, 729, 883	3		202. 00

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/22/2024 9:54 am
	T1 11 20011		

Name					5/22/2024 9:54 am
Ratio 11.00			Title XVIII	Hospi tal	Cost
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 30.00	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 2300 ADULTS & PEDI ATRI CS 30.00 ANCI LLARY SERVICE COST CENTERS 30.00 ANCI LLARY SERVICE COST CENTERS 50.00 50.00 05000 0PERATING ROOM 0.000000 53.00 53.00 05300 ANESTHESI OLOGY 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 64.00 06400 LABORATORY 0.000000 65.00 05500 RESPIRATORY THERAPY 0.000000 65.00 05500 RESPIRATORY THERAPY 0.000000 06500 RESPIRATORY THERAPY 0.000000 06500 RESPIRATORY THERAPY 0.000000 06500 RESPIRATORY THERAPY 0.000000 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72.00 07200 IMPLATIBLE EDVICES CHARGED TO 0.000000 72.00 07200 IMPLATIBLE EDVICES CHARGED TO 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.00000000					
30. 00 3000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS 50. 00 50000 OPERATING ROOM 50. 000		11. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM 0.000000 53. 00 53. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 06400 LABORATORY 0.000000 66. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 06500 RESPIRATORY THERAPY 0.000000 66. 00 06600 PRSPIRATORY THERAPY 0.000000 65. 00 06600 PRSPIRATORY THERAPY 0.000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 71. 00 071200 IMPLANTABLE DEVI CES CHARGED TO 0.000000 07200 IMPLANTABLE DEVI CES CHARGED TO 0.000000 073. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 073. 00 000000 000000 073. 00 000000 073. 00 000000 073. 00 000000 000000 000000 000000 000000					30.00
53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00	ANCILLARY SERVICE COST CENTERS				
54. 00	50.00 05000 OPERATING ROOM	0. 000000			50.00
60. 00	53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
64. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
65. 00	60. 00 06000 LABORATORY	0.000000			60.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 71. 00 71. 00 77. 00	64.00 06400 INTRAVENOUS THERAPY	0. 000000			64. 00
71. 00	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
72. 00 07200 MPLANTABLE DEVICES CHARGED TO 0.000000 72. 00 PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 000000 000000 000000 000000 000000	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0.000000			72. 00
SECOND SUBSTRUCT SUBSTRU	PATI ENTS				
88. 00 88. 01 88. 01 88. 02 91. 00 92. 00 07500 071000 071000 071000 071000 071000 071000 0710	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
88. 01	OUTPATIENT SERVICE COST CENTERS				
88. 02 08802 RURAL HEALTH CLINIC III	88.00 08800 RURAL HEALTH CLINIC				88. 00
91. 00	88.01 08801 RURAL HEALTH CLINIC II				88. 01
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE Subtotal (see instructions) 200.00	88.02 08802 RURAL HEALTH CLINIC III				88. 02
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00	91. 00 09100 EMERGENCY	0. 000000			91.00
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 200. 00 Subtotal (see instructions) 200. 00	92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 200.00 Subtotal (see instructions) 200.00	OTHER REIMBURSABLE COST CENTERS				
116. 00	101.00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions) 200.00	SPECIAL PURPOSE COST CENTERS				
	116. 00 11600 HOSPI CE		·	·	116. 00
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions)				200. 00
	201.00 Less Observation Beds				201. 00
202.00 Total (see instructions) 202.00	202.00 Total (see instructions)				202. 00

Heal th	Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre 5/22/2024 9:5	parea: 4 am
			Ti tl d	e XVIII	Hospi tal	Cost	4 4111
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	COST CONTENT DESCRIPTION		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	. Onar ges	COT GIIIIT 1)	
		26)	",				
		1.00	2. 00	3.00	4. 00	5. 00	
-	ANCILLARY SERVICE COST CENTERS			•	<u>'</u>		
50.00	05000 OPERATING ROOM	644, 659	7, 350, 924	0. 08769	8 6, 424	563	50.00
53.00	05300 ANESTHESI OLOGY	24, 396	1, 777, 921	0. 01372	2 1, 514	21	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	419, 773	20, 735, 271	0. 02024	4 162, 490	3, 289	54.00
60.00	06000 LABORATORY	161, 109	13, 524, 667	0. 01191	2 196, 876	2, 345	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	418, 976	0. 00000	0 2, 994	0	64. 00
65.00	06500 RESPIRATORY THERAPY	147, 314	3, 516, 415	0. 04189	338, 729	14, 190	65. 00
66. 00	06600 PHYSI CAL THERAPY	263, 106	4, 312, 517	0. 06101	0 70, 152	4, 280	66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	851	482, 871	0. 00176	2 55, 844	98	71. 00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	3, 520	628, 936	0. 00559	7 0	0	72.00
	PATI ENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	63, 744	5, 839, 512	0. 01091	6 210, 615	2, 299	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	157, 458	3, 256, 193	0. 04835	6 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	91, 109	1, 143, 148	0. 07970	0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	40, 282	557, 353	0. 07227	4 0	0	88. 02
91.00	09100 EMERGENCY	174, 637	7, 943, 319	0. 02198	5 1, 006	22	91.00
02 00	00200 OBSEDVATION PEDS (NON DISTINCT DART	10 201	121 071	0 15005	2 106	17	02 00

174, 637 19, 384

2, 211, 342

121, 871

71, 609, 894

0. 159053

1, 046, 750

106

22 91.00 17 92.00

27, 124 200. 00

91.00 | 09100 | EMERGENCY | 92.00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50 through 199)

Health Financial Systems	PANA COMMUNIT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CC	CN: 14-1341	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/22/2024 9:54	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments		

Non Physician Anesthetist Cost				Title	XVIII	Hospi tal	Cost	
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00		Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments 1.00 2A 2.00 3A 3.00			Anestheti st	Program	Program			
1.00 2A 2.00 3A 3.00			Cost			Adjustments		
ANCILLARY SERVICE COST CENTERS				Adjustments				
50. 00 05000 OPERATI NG ROOM 0 0 0 0 0 0 50. 00 53. 00 05300 ANESTHESI OLOGY 414, 821 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0			1.00	2A	2. 00	3A	3. 00	
53. 00 05300 ANESTHESI OLOGY 414, 821 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0	50.00		0	0	(0	0	50. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	53.00	05300 ANESTHESI OLOGY	414, 821	0	(0	0	53. 00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 00174TIENT SERVICE COST CENTERS 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC 11 0 0 0 0 89. 02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 94. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 94. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 95. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 95. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 96. 00 00 00 00 00 97. 00 00 00 00 00 98. 00 00 00 00 99. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 00 90. 00 00 90. 00 00 00 90. 00 00 90. 00 00 00 90. 00			0	0	(0	0	54.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 00 0 0 0		l	0	0	(0	0	60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 0 PATIENTS 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0000 0000 0000 0000 0000 0000 0000 0000 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC 1 0 0 0 0 0 88. 02 08802 RURAL HEALTH CLINIC 1 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 93. 00 0000 0000 0000 0000 0000 0000 94. 00 0000 0000 0000 0000 95. 00 0000 0000 0000 96. 00 00 00 00 97. 00 0000 0000 97. 00 0000 0000 97. 00 0000 0000 97. 00 0000 98. 0000 0000 992. 00 0000 992. 00 0000 9000 0000		l	0	0	(0	0	64. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 72. 00 MPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 073. 00 073.00		l	0	0	(0	0	65. 00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 72. 00	66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00	72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	(0	0	72. 00
SERVICE COST CENTERS		PATI ENTS						
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 01 88. 01 88. 02 88. 02 88. 02 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 02 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 92. 00 92. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 92. 00		OUTPATIENT SERVICE COST CENTERS						
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 92. 00 09	88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
91. 00 09100 EMERGENCY	88. 01	08801 RURAL HEALTH CLINIC II	0	0	(0	0	88. 01
92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 92.00	88. 02	08802 RURAL HEALTH CLINIC III	0	0	(0	0	88. 02
	91.00	09100 EMERGENCY	0	0	(0	0	91.00
200 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92.00
200.00 Total (Tines 50 through 199) 414,821 0 0 0 0 200.00	200.00	Total (lines 50 through 199)	414, 821	0	(0	0	200. 00

Health Financial Systems	PANA COMMUNI	TV HOSDITAI		In Lie	u of Form CMS-2	DEE2 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		S Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 7, 350, 924	0. 000000	50. 00
53. 00 05300 ANESTHESI OLOGY	0	414, 821		0 1, 777, 921	0. 233318	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 20, 735, 271	0.000000	54.00
60. 00 06000 LABORATORY	0	0)	0 13, 524, 667	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0)	0 418, 976	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	0 3, 516, 415	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 4, 312, 517	0. 000000	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	,	0 482, 871	0. 000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0	,	0 628, 936	0. 000000	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 5, 839, 512	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			,			İ
88. 00 08800 RURAL HEALTH CLINIC	0	0)	0 3, 256, 193	0.000000	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0)	0 1, 143, 148	0. 000000	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	0)	0 557, 353		88. 02
91. 00 09100 EMERGENCY	0	0	,	0 7, 943, 319		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	,	0 121, 871	0. 000000	
200.00 Total (lines 50 through 199)	0	414, 821		0 71, 609, 894		200. 00
	1	1, 52.	1	-1, 55,75,1		,====

				III LIC	u of Form CMS-2	2002-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023 Fo 12/31/2023	Part IV Date/Time Pre	nanad.
			10 12/31/2023	5/22/2024 9:5		
		Title	XVIII	Hospi tal	Cost	1 4111
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	1	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	6, 424		0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 514		3 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	162, 490		0	0	54.00
50. 00 06000 LABORATORY	0. 000000	196, 876		0	0	60.00
54. 00 06400 I NTRAVENOUS THERAPY	0. 000000	2, 994		0	0	64. 00
55. 00 06500 RESPIRATORY THERAPY	0. 000000	338, 729	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	70, 152	(0	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	55, 844	(0	0	71. 00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	0	(0	0	72. 00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	210, 615	(0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0. 000000	0	(0	0	88. 00
38.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	(0	0	88. 01
38.02 08802 RURAL HEALTH CLINIC III	0. 000000	0	(0	0	88. 02
91. 00 09100 EMERGENCY	0. 000000	1, 006	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	106	(0	0	92.00
200.00 Total (lines 50 through 199)		1, 046, 750	353	3 0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1341 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 361574 1, 728, 721 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 297054 443, 556 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.142088 6, 543, 322 54.00 0 0 60.00 06000 LABORATORY 0.173627 0 3, 716, 862 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0. 115990 168, 962 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.406299 0 1, 025, 898 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.460198 1, 263, 084 0 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 136902 129, 454 0 71.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 72.00 0. 757452 167, 613 0 72.00 PATI ENTS 07300 DRUGS CHARGED TO PATIENTS 73.00 0.301007 2, 988, 565 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 09100 EMERGENCY 91.00 0.471177 2, 439, 054 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 290914 51, 675 0 92.00 Subtotal (see instructions) 200.00 200.00 20, 666, 766 0 201.00 Less PBP Clinic Lab. Services-Program 201. 00 \cap Only Charges

20, 666, 766

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems		PANA COMMUNITY I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	D VACCINE COST	Provider CCN: 14-1341	Peri od: From 01/01/2023	Worksheet D
					Data/Time Drapared

				To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	/2F 0/1		I			50.00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	625, 061					53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	131, 760					54.00
60. 00 06000 LABORATORY	929, 728					60.00
64. 00 06400 I NTRAVENOUS THERAPY	645, 348 19, 598					64.00
65. 00 06500 RESPI RATORY THERAPY	416, 821					65.00
66. 00 06600 PHYSI CAL THERAPY						66.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	581, 269					71.00
	17, 723					71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	126, 959	0				/2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	899, 579	0				73. 00
OUTPATIENT SERVICE COST CENTERS		_				
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
88.02 08802 RURAL HEALTH CLINIC III						88. 02
91. 00 09100 EMERGENCY	1, 149, 226	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	66, 708	0				92.00
200.00 Subtotal (see instructions)	5, 609, 780	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 609, 780	0				202. 00

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1341	From 01/01/2023	Worksheet D-1 Date/Time Prepared:
			5/22/2024 9:54 am
	Title XVIII	Hospi tal	Cost

				5/22/2024 9:5	4 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 739	1.00
2.00	Inpatient days (including private room days, excluding swing-b			716	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			616	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	1, 001	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	22	7. 00
0.00	reporting period	D 2	1 -6	0	0 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after becember 3	or the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	cwing had and	336	9. 00
9.00	newborn days) (see instructions)	The Program (excruding	Swifig-bed and	330	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	907	10.00
10.00	through December 31 of the cost reporting period (see instruct		oom days)	707	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11.00
00	December 31 of the cost reporting period (if calendar year, er		oom dayo, arron	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 1	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (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 service	es through December 31 o	f the cost		17. 00
40.00	reporting period	CI D I 01 C			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombon 21 of	the cost	208. 70	10 00
19.00	reporting period	s till ought beceiliber 31 of	the cost	200.70	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions	5)		2, 705, 874	21. 00
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)		- '		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	4, 591	24. 00
25 00	7 x line 19))1 -£ +L++!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	si of the cost reporting	perrod (Trie 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			1, 579, 424	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1, 126, 450	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21 11110 20)		17 1207 100	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		. 3,	0	29. 00
30.00	Semi -pri vate 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 mir	nus line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 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 a	and private room cost di	fferential (line	1, 126, 450	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUFUTO			
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 570 51	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 573. 26	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		528, 615	39.00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)			0 528, 615	40.00
41.00	Trotal trogram general impatrent routine service cost (Title 39	11116 40)	l	520, 013	41.00

				1.1	From 01/01/2023		
					To 12/31/2023		
				e XVIII	Hospi tal	Cost	1 4111
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	3.00	4.00	5.00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					301, 953	48. 00
48. 01	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 830, 568	
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46. 0	i) (see Tiisti u	oti olis)		630, 366] 49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fi	rom Wkst. D, sı	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)		•			
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use onlv)				0. 00 0. 00	1
	Target amount (line 54 x sum of lines 55, 55					0	1
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
8. 00 9. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period a	anding 1006	0.00	
	updated and compounded by the market basket)		·	0.			
50. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year o	cost report, u	odated by the	0.00	60.00
1. 00	Continuous improvement bonus payment (if lin					0	61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		the target a		,, στισι σσ	_	
52. 00 53. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	`	ĺ				
54. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	1, 426, 947	64.00
55. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line (65)(title XVII	l only); for	1, 426, 947	66.00
	CAH, see instructions	·	•	, ,	3,		
57. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 (or the cost re	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N]
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70.00
72. 00	Program routine service cost (line 9 x line			•			72. 00
73. 00	Medically necessary private room cost applic		•				73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74.00
0.00	26, line 45)	routine service	00313 (1101111	NOT ROTICOL B, TV	are rr, corumn		70.00
76.00	Per diem capital related costs (line 75 ÷ li	. *					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79. 00
30. 00	Total Program routine service costs for comp	arison to the c		*.	us line 79)		80.00
31.00	Inpatient routine service cost per diem limi		`				81.00
32. 00 33. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
34. 00	Program inpatient ancillary services (see in		-,				84. 00
35. 00	Utilization review - physician compensation	(see instructio					85. 00
36. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86. 00
37. 00	Total observation bed days (see instructions					100	87. 00

100 87.00 1,573.25 88.00 157,325 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	PANA COMMUNIT	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/22/2024 9:54	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	333, 398	2, 705, 874	0. 12321	3 157, 325	19, 384	90.00
91.00 Nursing Program cost	0	2, 705, 874	0.00000	0 157, 325	0	91.00
92.00 Allied health cost	0	2, 705, 874	0.00000	0 157, 325	0	92.00
93.00 All other Medical Education	0	2, 705, 874	0. 00000	0 157, 325	0	93. 00

Health Fina	ncial Systems PANA COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 14-1341	Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
LNDA	FLENT POLITIME CERVILOE COCT CENTERS		1.00	2. 00	3. 00	
	FIENT ROUTINE SERVICE COST CENTERS			440.007		20.00
	ADV SERVICE COST CENTERS			440, 806		30.00
	LLARY SERVICE COST CENTERS DOPERATING ROOM		0. 36157	6, 424	2, 323	50.00
	O ANESTHESI OLOGY		0. 3015			1
	C RADI OLOGY-DI AGNOSTI C		0. 14208			
•	LABORATORY		0. 14200			
	I NTRAVENOUS THERAPY		0. 11599			64. 00
	RESPIRATORY THERAPY		0. 40629			
•	PHYSI CAL THERAPY		0. 46019		· ·	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13690		7, 645	
	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 75745		0	72. 00
•	DRUGS CHARGED TO PATIENTS		0. 30100		63, 397	
OUTP	ATLENT SERVICE COST CENTERS		•			İ
88. 00 0880	RURAL HEALTH CLINIC		0.00000	00	0	88. 00
88. 01 0880	1 RURAL HEALTH CLINIC II		0.00000	00	0	88. 01
88. 02 0880	RURAL HEALTH CLINIC III		0.00000	00	0	88. 02
	EMERGENCY		0. 47117	1, 006	474	91. 00
	OBSERVATION BEDS (NON-DISTINCT PART		1. 29091			92. 00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			1, 046, 750	301, 953	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			1, 046, 750		202. 00

Heal th	Financial Systems	PANA COMMUNITY HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 14-1341	Peri od:	Worksheet D-3	
		Component	CCN: 14-Z341	From 01/01/2023 To 12/31/2023		
		Ti tl e		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1			
H	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM		0.2/15	7.4		F0 00
	D5300 ANESTHESI OLOGY		0. 3615 0. 2970		0	50. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 2970			54.00
	06000 LABORATORY		0. 1736			
	06400 I NTRAVENOUS THERAPY		0. 1159			
	06500 RESPIRATORY THERAPY		0. 40629			
1	06600 PHYSI CAL THERAPY		0. 46019			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13690			71. 00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 7574!	52 0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS		0. 3010	379, 758	114, 310	73. 00
	DUTPATIENT SERVICE COST CENTERS		_			
	D8800 RURAL HEALTH CLINIC		0.00000		0	
	08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
	D8802 RURAL HEALTH CLINIC III		0. 00000		0	88. 02
	09100 EMERGENCY		0. 4711		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 2909		0	92.00
200.00	Total (sum of lines 50 through 94 and 96			1, 756, 518		
201.00	Less PBP Clinic Laboratory Services-Progr	am only charges (line 61)		1 754 510	1	201. 00
202. 00	Net charges (line 200 minus line 201)		1	1, 756, 518	1	202. 00

	Title XVIII Hospital	Cost	+ alli
		1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1. 00	
1.00	Medical and other services (see instructions)	5, 609, 780	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2. 00
3.00	OPPS or REH payments	0	3. 00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	0	4. 00 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 acqui si ti ons	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	5, 609, 780	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12.00	Reasonable charges	0	12 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	12. 00 13. 00
14. 00		o o	14. 00
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	0.000000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
	instructions)		
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)	5, 665, 878	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
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	42, 290	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3, 336, 017	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	2, 287, 571	27. 00
00.00	instructions)		00.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount (see instructions)	0	28. 00 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)	2, 287, 571	
31. 00	Pri mary payer payments	709	31. 00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	2, 286, 862	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34. 00	Allowable bad debts (see instructions)	428, 626	34. 00
35.00		278, 607	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	428, 626	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	2, 565, 469 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	_	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98 39. 99
40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	2, 565, 469	40. 00
40. 01	Sequestration adjustment (see instructions)	51, 309	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	3, 036, 557	41. 00 41. 01
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)	0	41.01
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43. 00	Balance due provider/program (see instructions)	-522, 397	43.00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44. 00
	TO BE COMPLETED BY CONTRACTOR		
90. 00	Original outlier amount (see instructions)	0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)	0	91. 00
92.00		0.00	92. 00 93. 00
73.00	Time Value of Money (see instructions)	١	73.00

Health Financial Systems	PANA COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1341	Peri od: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems PANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1341

					5/22/2024 9: 5	4 am
		Title	: XVIII	Hospi tal	Cost	
		I npati en	it Part A	Par	t 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, 063, 609		3, 026, 942	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) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	07/19/2023	90, 266	07/19/2023	9, 782	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER	0771972023	90, 200	077 197 2023	9, 782	3. 01
3. 02			0		0	3. 02
3.03			0			3. 03
3. 05			0			3. 04
3.03	Provider to Program		U		U	3.03
3. 50	ADJUSTMENTS TO PROGRAM	12/06/2023	216, 849	12/06/2023	167	3. 50
3. 51	ADSOSTMENTS TO TROOMAIN	12/00/2025	210, 047	12/00/2023	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		-126, 583		9, 615	3. 99
	3. 50-3. 98)		·		·	
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		937, 026		3, 036, 557	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		235, 739		522, 397	6. 02
7. 00	Total Medicare program liability (see instructions)		701, 287		2, 514, 160	7. 00
,.00	1.0 tal. mourouro program readitity (300 filatiactions)		701, 207	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•	'		. '	

Health Financial Systems PANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		·			5/22/2024 9: 5	4 am
				wing Beds - SNF		
		Inpatien	t Part A	Par	rt 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		2, 232, 920		0	1. 00
2.00	Interim payments payable on individual bills, either		0		l ol	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/19/2023	55, 333		0	3. 01
3.02		12/06/2023	35, 281		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		90, 614		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 323, 534		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	Г	T	T		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program		_	T	_	
5. 50	TENTATI VE 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					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		298, 261		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 025, 273		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems PANA COMMUNITY HOSPITAL In Lie		eu of Form CMS-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1341	Peri od: From 01/01/2023 To 12/31/2023		epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	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	0 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 cline 168	ertified HIT technology	Wkst. S-2, Pt. I		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				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	O Belance due provider (line 9 (or line 10) minus line 30 and line 31) (see instructions)				22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Component CCN: 14-Z341 To 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Title XVIII Swing Beds - SNF Cost Part A Part B 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 1, 441, 216 0 1.00 Inpatient routine services - swing bed-NF (see instructions) 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Λ 3.00 660, 189 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) Nursing and allied health payment-PARHM (see instructions) 3.01 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5. 00 Program days 907 Λ 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 7.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 2. 101. 405 8.00 8 00 0 Primary payer payments (see instructions) 9.00 0 9.00 10.00 Subtotal (line 8 minus line 9) 2, 101, 405 0 10.00 11.00 Deductibles billed to program patients (exclude amounts applicable to physician 0 11.00 professional services) 12 00 Subtotal (line 10 minus line 11) 2, 101, 405 0 12 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 34, 800 0 13.00 13.00 for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (see instructions) 2, 066, 605 0 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 16.55 0 16.55 adjustment (see instructions) 16. 99 ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 16.99 Ω 0 17.00 Allowable bad debts (see instructions) 0 0 17.00 Adjusted reimbursable bad debts (see instructions) 0 17.01 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 0 0 2, 066, 605 19.00 Total (see instructions) Ω 19 00 19. 01 Sequestration adjustment (see instructions) 41, 332 0 19.01 19. 02 Demonstration payment adjustment amount after sequestration) 19.02 Sequestration adjustment-PARHM pass-throughs 19.03 19.03 19. 25 Sequestration for non-claims based amounts (see instructions) 0 19. 25 20.00 Interim payments 2. 323. 534 20.00 20.01 Interim payments-PARHM 20.01 21.00 Tentative settlement (for contractor use only) 0 21 00 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) -298, 261 22.00 Balance due provider/program-PARHM (see instructions) 22.01 22.01 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 Λ 23.00 chapter 1, §115.2 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 201.00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 200 (title XVIII swing-bed SNF)) 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 peri od) 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 1 208. 00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00

instructions)

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1341	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/22/2024 9:54 am
	T' 11 \0.00 11		

	Title XVIII Hospital	5/22/2024 9: 54 Cost	4 am			
	1.0					
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services	830, 568	1.00			
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00			
3. 00	Organ acqui si ti on	l ol	3. 00			
3. 01	Cellular therapy acquisition cost (see instructions)	l ol	3. 01			
4.00	Subtotal (sum of lines 1 through 3.01)	830, 568	4.00			
5.00	Primary payer payments	0	5. 00			
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	838, 874	6. 00			
	COMPUTATION OF LESSER OF COST OR CHARGES					
	Reasonable charges					
7.00	Routi ne servi ce 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	0	12. 00			
	had such payment been made in accordance with 42 CFR 413.13(e)					
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	0	15. 00			
	instructions)					
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00			
	instructions)					
17. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	17. 00			
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0				
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	838, 874				
20.00	Deductibles (exclude professional component)	145, 336				
21. 00	Excess reasonable cost (from line 16)	0	21.00			
22. 00	Subtotal (line 19 minus line 20 and 21)	693, 538				
23. 00	Coinsurance	0	23. 00			
24. 00	Subtotal (line 22 minus line 23)	693, 538				
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33, 940				
26. 00	Adjusted reimbursable bad debts (see instructions)	22, 061				
27. 00 28. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33, 940 715, 599				
28.00	Subtotal (sum of lines 24 and 25, or line 26)	715, 599	28.00			
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		29. 00			
29. 50	Recovery of accelerated depreciation.		29. 50			
29. 90	Demonstration payment adjustment amount before sequestration		29. 90			
30.00	Subtotal (see instructions)	715, 599	30.00			
30. 00	Sequestration adjustment (see instructions)	14, 312				
30. 01	Demonstration payment adjustment amount after sequestration	14, 312	30. 01			
30. 02	Sequestration adjustment-PARHM		30. 02			
31. 00	Interim payments	937, 026				
31. 00	Interim payments	737, 020	31. 00			
32. 00	Tentative settlement (for contractor use only)	o	32.00			
32. 01	Tentative settlement-PARHM (for contractor use only)		32. 01			
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-235, 739				
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)	255, 757	33. 01			
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	o	34. 00			
5 r. 00	\$115. 2	ا	0 1. 00			
	19 -	1	'			

Health Financial Systems PANA COMMU BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column

Provider CCN: 14-1341

| Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/22/2024 9:54 am onl y)

oni y)			'	0 12/01/2020	5/22/2024 9:5	4 am
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17, 221, 711	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	5, 065, 559	0	o	0	4.00
5.00	Other recei vabl e	412, 566	1	ol	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	1 _	ol	0	•
7. 00	Inventory	813, 483	0	أم	0	•
8.00	Prepaid expenses	200, 908	1	0	0	
9. 00	Other current assets	200, 700	l o	ام	0	
10. 00	Due from other funds	77, 342	0	o	0	
11. 00		23, 791, 569		_	0	11. 00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	23, 791, 309	1 0	<u> </u>	0	11.00
10.00		121 721		ا	0	12.00
12.00	Land	131, 721	1		0	•
13.00	Land improvements	2, 846, 510	1	_	0	
14. 00	Accumulated depreciation	-1, 103, 277	1	0	0	
15. 00	Bui I di ngs	32, 829, 757	1	0	0	
16. 00	Accumul ated depreciation	-12, 521, 599	0	0	0	
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	2, 096, 306	0	0	0	19. 00
20.00	Accumulated depreciation	-628, 712	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	6, 927, 504	. 0	o	0	23. 00
24.00	Accumul ated depreciation	-4, 368, 135	0	o	0	24. 00
25.00	Mi nor equi pment depreci able	0	0	ol	0	25. 00
26. 00	Accumul ated depreciation	0	0	ol	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	ı
28. 00	Accumul ated depreciation	0	0	Ö	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	57, 245	_	Ö	0	•
30. 00	Total fixed assets (sum of lines 12-29)	26, 267, 320	1	_		
30.00	OTHER ASSETS	20, 207, 320	1 0	l V	0	30.00
21 00	Investments	4 524 452	0	ol	0	21 00
31.00		6, 534, 653	0			
32. 00	Deposits on Leases	0		0	0	32.00
33. 00	Due from owners/officers		1 0	0	0	
34. 00	Other assets	638, 339		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	7, 172, 992	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	57, 231, 881	0	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	1, 090, 921	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 188, 220	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	435, 579	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0)		1	42.00
43.00	Due to other funds	0	0	o	0	43.00
44.00	Other current liabilities	435, 701	0	o	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 150, 421	0	o	0	45. 00
	LONG TERM LIABILITIES	.,,		<u> </u>		1
46.00	Mortgage payable	Ω	0	ol	0	46. 00
47. 00	Notes payable	7, 217, 144	1	l ől	0	
48. 00	Unsecured Loans	7,217,111	l ő	l ől	0	ı
49. 00	Other long term liabilities	0	0	Ö	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	7, 217, 144	_	_		
51. 00	Total liabilities (sum of lines 45 and 50)	11, 367, 565				1
31.00	CAPITAL ACCOUNTS	11, 307, 303	1 0	ı v	0	31.00
E2 00		4E 0/4 21/				E2 00
52. 00	General fund balance	45, 864, 316			1	52.00
53.00	Specific purpose fund		0		1	53. 00
54.00	Donor created - endowment fund balance - restricted			0	1	54.00
55. 00	Donor created - endowment fund balance - unrestricted			이	ı	55. 00
56. 00	Governing body created - endowment fund balance			0	ı	56. 00
57. 00	Plant fund balance - invested in plant				0	•
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion				1	
59. 00	Total fund balances (sum of lines 52 thru 58)	45, 864, 316	1	0	0	•
60.00	Total liabilities and fund balances (sum of lines 51 and	57, 231, 881	0	0	0	60.00
	59)					

Provider CCN: 14-1341

					To 12/31/2023	Date/Time Prep 5/22/2024 9:54	
		General	Fund	Special P	urpose Fund	Endowment Fund	+ aiii
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	38, 785, 934	3.00	4.00		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		6, 168, 031				2. 00
3.00	Total (sum of line 1 and line 2)		44, 953, 965		0		3. 00
4. 00	CHANGE IN NET ASSETS	916, 550	11,700,700	1	0	0	4. 00
5. 00		0			0	0	5. 00
6.00		o				0	6. 00
7.00		o			0	0	7.00
8.00		o			0	0	8. 00
9.00		O			O	0	9. 00
10.00	Total additions (sum of line 4-9)		916, 550		0		10.00
11. 00	Subtotal (line 3 plus line 10)		45, 870, 515		0		11.00
12.00	LOOS ON INVESTMETN IN QUAD CTY HMS	6, 199			0	0	12.00
13.00		O			O	0	13.00
14.00		0			O	0	14.00
15.00		0			O	0	15.00
16.00		0			O	0	16.00
17. 00		0			O	0	17.00
18. 00	Total deductions (sum of lines 12-17)		6, 199		0		18.00
19. 00	Fund balance at end of period per balance		45, 864, 316		0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	Dlant	Fund			
		Endownient Fund	PLAIIL	Fullu	_		
		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			O		3.00
4.00	CHANGE IN NET ASSETS		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			O		11.00
12.00	LOOS ON INVESTMETN IN QUAD CTY HMS		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00			0				15. 00 16. 00
16.00			0				
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0		o		17. 00 18. 00
19. 00	Fund balance at end of period per balance	0			0		19.00
17.00	sheet (line 11 minus line 18)						17.00
	Janoce (Time II milius IIIIe 10)	1		I	1		

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1341

		'	0 12/31/2023	5/22/2024 9:54	
	Cost Center Description	Inpatient	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	869, 816		869, 816	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	894, 960		894, 960	5.00
6.00	Swing bed - NF	34, 320		34, 320	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, 799, 096		1, 799, 096	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>			
11. 00	INTENSIVE CARE UNIT				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 I	i nes (0	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 799, 096	1	1, 799, 096	17. 00
18. 00	Ancillary services	4, 012, 149		58, 906, 327	18. 00
19. 00	Outpati ent servi ces	53, 748		8, 185, 296	19. 00
20. 00	RURAL HEALTH CLINIC		-,,	3, 256, 193	20.00
20. 01	RURAL HEALTH CLINIC II			1, 143, 148	20. 01
20. 02	RURAL HEALTH CLINIC III		/	557, 353	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00
22. 00	HOME HEALTH AGENCY		1, 475, 474	1, 475, 474	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	(848, 129	26. 00
27. 00	PROFESSIONAL FEES	252, 622		9, 733, 678	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 6, 117, 615	79, 787, 079	85, 904, 694	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		36, 508, 274		29. 00
30. 00	ADD (SPECIFY)				30.00
31. 00	ADD (SELCTIT)				31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)				36. 00
37. 00	DEDUCT (SPECIFY)		J		37. 00
38. 00	DEDUCT (SI ECITI)				38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					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	36, 508, 274		43. 00
.5. 55	to Wkst. G-3, line 4)		33, 333, 214		.5. 00
		•	. '		

		A COMMUNITY HOSPITAL		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 14-1341	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre	pared:
				5/22/2024 9: 5	
1 00				1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, co			85, 904, 694	
2.00	Less contractual allowances and discounts on patie	ents' accounts		47, 553, 489	
3.00	Net patient revenues (line 1 minus line 2)			38, 351, 205	
4.00	Less total operating expenses (from Wkst. G-2, Par			36, 508, 274	
5.00	Net income from service to patients (line 3 minus	line 4)		1, 842, 931	5. 00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			1, 143, 404	
8.00	Revenues from telephone and other miscellaneous co	ommunication sorvices		1, 143, 404	1
9.00	Revenue from television and radio service	online in Cation Services		0	1
10.00	Purchase di scounts			0	ı
11. 00				-	11.00
12.00	Parking lot receipts			0	
13. 00				0	
	Revenue from meals sold to employees and guests			91, 580	
	Revenue from rental of living quarters			91, 300	1
16. 00		s to other than nationts		0	
	Revenue from sale of drugs to other than patients			0	1
	Revenue from sale of medical records and abstracts				18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)	3		0	1
	Revenue from gifts, flowers, coffee shops, and car	nteen		0	1
	Rental of vending machines	110011			21.00
	Rental of hospital space			54, 552	
23. 00	Governmental appropriations			22, 435	
24. 00	RETAIL PHARMACY			120, 113	
24. 01	FITNESS CENTER REVENUE			63, 916	
	MI SCELLANEOUS REVENUE			2, 828, 987	
	COVI D-19 PHE Funding			0	
	Total other income (sum of lines 6-24)			4, 325, 100	
	Total (line 5 plus line 25)			6, 168, 031	
	OTHER EXPENSES (SPECIFY)			0	1
	Total other expenses (sum of line 27 and subscript	ts)		0	1

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

0 28.00 6, 168, 031 29.00

O

0

1, 378, 959

0

0

23.00

23.50

24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

1, 378, 959

All Others (specify)

24.00 Total (sum of lines 1-23)

Tel emedi ci ne

23.00

23. 50

Heal th	Financial Systems		PANA COMMUNITY	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 14-1341	Peri od:	Worksheet H-1 Part I	
				HHA CCN:	14-7299	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
						Home Health	5/22/2024 9: 5 PPS	<u>4 am</u>
						Agency I	1.0	
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on	Subtotal	
		for Cost Allocation	Fixtures	Equi pment	Operation 8		(cols. 0-4)	
		(from Wkst. H,			Marriconario			
		col . 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	4.00	4A. 00	
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1. 00
2.00	Capital Related - Movable	0		0			0	2. 00
3. 00	Equipment Plant Operation & Maintenance		0	0		0	0	3. 00
4. 00	Transportation	0	Ö	0		0 0	0	4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	352, 939	0	0		0 0	352, 939	5. 00
6. 00	Skilled Nursing Care	513, 474	0	0		0 0	513, 474	6. 00
7.00	Physical Therapy	413, 879	0	0		0 0	413, 879	
8. 00 9. 00	Occupational Therapy Speech Pathology	43, 962 13, 284	0	0		0 0	43, 962 13, 284	1
10.00	Medical Social Services	7, 780	0	0		0 0	7, 780	10. 00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	4, 016 29, 625	0	0		0 0		11. 00 12. 00
13.00	Drugs	0	Ö	Ö		0	0	1
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
18. 00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0	0		0 0	0	
22. 00	Homemaker Service	0	0	0		0 0	0	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0		0 0	0	
	Total (sum of lines 1-23)	1, 378, 959	0	0	•	0 0	1, 378, 959	
		Administrative & General	lotal (cols. 4A + 5)					
		5.00	6.00					
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment							2. 00
3.00	Plant Operation & Maintenance							3. 00
4. 00 5. 00	Transportation Administrative and General	352, 939						4. 00 5. 00
3.00	HHA REIMBURSABLE SERVICES	332, 737						3.00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	176, 630 142, 369	690, 104 556, 248					6. 00 7. 00
8. 00	Occupational Therapy	15, 122	59, 084					8. 00
9.00	Speech Pathology Medical Social Services	4, 570	17, 854					9.00
10. 00 11. 00	Home Health Aide	2, 676 1, 381	10, 456 5, 397					10. 00 11. 00
12.00	Supplies (see instructions)	10, 191	39, 816					12.00
13. 00 14. 00	Drugs DME	0 0	0					13. 00 14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0 0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20. 00	1	0	0					20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
23. 00		0	0					23. 00
23. 50		0	1 279 050					23. 50
∠4. UU	Total (sum of lines 1-23)	I	1, 378, 959					24.00

COST A	LLOCATION - HHA STATISTICAL BAS	SLS		Provi der Co	CN: 14-1341	Peri od:	Worksheet H-1	
				HHA CCN:	14-7299	From 01/01/2023 To 12/31/2023		pared: 4 am
						Home Health Agency I	PPS	
		Capital Rel	ated Costs			Agency		
		Bl dgs &	Movabl e	PI ant	Transpartati	onReconciliation	Admi ni strativo	1
		Fixtures	Equi pment	Operation &	(MI LEAGE)	onkeconci i i ati on	& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		1 00	0.00	(SQUARE FEET)	4.00	FA 00	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5A. 00	5. 00	
1. 00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable		0			0		2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0		3.00
3. 00 4. 00	Transportation (see		0	0		0		4.00
00	instructions)							
5. 00	Administrative and General	0	0	0		0 -352, 939	1, 026, 020	5.00
	HHA REIMBURSABLE SERVICES	1			1			
6.00	Skilled Nursing Care	0	0	0		0 0		
7. 00 8. 00	Physical Therapy Occupational Therapy	0	0	0		0	413, 879 43, 962	
9. 00	Speech Pathology		0	0			13, 284	•
10.00	Medical Social Services	l o	o o	Ö		o o	7, 780	•
11. 00	Home Health Aide	0	0	0		0 0	4, 016	
12. 00	Supplies (see instructions)	0	0	0		0 0	29, 625	12.00
13. 00	Drugs	0	0	0		0	0	
14. 00	DME	0	0	0		0 0	0	14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	Ιο	0	0		0 0	0	15.00
16. 00	Respiratory Therapy		0	0		0 0		16.00
17. 00	Private Duty Nursing	l o	o o	Ö		o o	1	17. 00
18. 00	Clinic	0	0	0		0 0	0	18.00
19. 00	Health Promotion Activities	0	0	0		0 0	0	19.00
20. 00	Day Care Program	0	0	0		0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22. 00	Homemaker Service	0	0	0		0 0	0	22.00
23. 00 23. 50	All Others (specify) Telemedicine		0			0		23. 00 23. 50
23. 30	Total (sum of lines 1-23)		0	0		0 -352, 939	1, 026, 020	
25. 00	Cost To Be Allocated (per	0	0	0		0	352, 939	
	Worksheet H-1, Part I)]	
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 343988	26, 00

Worksheet H-2 Part I Date/Time Prepared: 5/22/2024 9:54 am Provider CCN: 14-1341 Peri od: From 01/01/2023 To 12/31/2023 HHA CCN: 14-7299 Home Health PPS

						Home Health Agency I	PPS	
			CAPI	TAL RELATED CO	STS	Agency		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	
		0	1.00	1. 01	2. 00	4. 00	5. 01	
1.00	Administrative and General	0	41, 316	0	25, 518	50, 180	1, 820	1. 00
2.00	Skilled Nursing Care	690, 104	5, 012	0	0	149, 891	4, 248	2. 00
3.00	Physi cal Therapy	556, 248	620	0	0	94, 486	1, 213	3. 00
4.00	Occupational Therapy	59, 084	316	0	0	7, 757	607	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	17, 854 10, 456	134	0	0	3, 358 2, 271	0	5. 00 6. 00
7. 00	Home Heal th Aide	5, 397	97	0	0	2, 27 1 1, 172	0	7. 00
8. 00	Supplies (see instructions)	39, 816	, o	0	0	0	Ö	8. 00
9. 00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0	0	0	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	Ō	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19.00	All Others (specify)	0	0	0	0	0	1, 213	19. 00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	1, 378, 959	0 47, 495	0	25, 518	309, 115	9, 101	19. 50 20. 00
21. 00	Unit Cost Multiplier: column	1, 370, 737	47, 475	O	23, 310	307, 113	9, 101	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	DATA	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN	OPERATION OF	LAUNDRY &	
	oost conten beschiptron	PROCESSI NG	OUNTS	Subtotal	AND GENERAL	PLANT	LINEN SERVICE	
			RECEI VABLE					
1 00	Administrative and General	5. 02	5. 03	5A. 03	5. 04	7. 00	8. 00	1 00
1. 00 2. 00	Skilled Nursing Care	17, 744 17, 744	0	136, 578 866, 999	12, 607 80, 028	111, 689 13, 550	0	1. 00 2. 00
3.00	Physical Therapy	3, 549	o	656, 116	60, 562		0	3. 00
4. 00	Occupational Therapy	0	0	67, 764	6, 255		0	4. 00
5.00	Speech Pathology	0	0	21, 346	1, 970	362	0	5.00
6.00	Medical Social Services	0	0	12, 727	1, 175		0	6. 00
7.00	Home Heal th Ai de	0	0	6, 666	615		0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	39, 816	3, 675 0	0	0	8. 00 9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	Ö	o	0	0	0	O	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00		0	0	0	0	0	0	14. 00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	Ö	ő	0	0	0	Ö	18. 00
19.00		7, 098	o	8, 311	767	0	0	19.00
	All Others (specify)	,,0,0						
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	0 46, 135	0	0 1, 816, 323	0 167, 654	0 128, 396	0	20. 00
19. 50	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	-	0 1, 816, 323 0. 000000	0 167, 654	128, 396	0	
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0	-		0 167, 654	128, 396	0	20. 00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	-		0 167, 654	128, 396	0	20. 00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0	-		0 167, 654	0 128, 396	0	20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

						Home Health Agency I	PPS	1 4111
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		9. 00	10.00	11. 00	13.00	14.00	15. 00	
2. 00 Ski 3. 00 Phy 4. 00 Occ 5. 00 Mec 7. 00 Hor 8. 00 Sup 9. 00 Dr. 11. 00 DMI 11. 00 Hor 12. 00 Res 13. 00 Pri 14. 00 Cl i 15. 00 Hea 16. 00 Day 17. 00 Hor 18. 00 Hor 19. 00 Al I 19. 50 Tel 20. 00 Tot 21. 00 Uni	me Dialysis Aide Services spiratory Therapy ivate Duty Nursing inic alth Promotion Activities y Care Program me Delivered Meals Program memaker Service I Others (specify) lemedicine tal (sum of lines 1-19) (2) it Cost Multiplier: column , line 1 divided by the sum column 26, line 20 minus	30, 120 4, 477 554 283 120 0 87 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 311 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	lumn 26, line 1, rounded to decimal places.							
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16. 00	17. 00	19. 00	24.00	25. 00	26.00	
2. 00 Ski 3. 00 Phy 4. 00 Occ 5. 00 Mec 7. 00 Hor 8. 00 Sup 9. 00 Dru 10. 00 DM 11. 00 Hor 12. 00 Res 13. 00 Pri 14. 00 Cl i 15. 00 Hor 15. 00 Hor 17. 00 Hor 18. 00 Hor 19. 00 Al I 19. 50 Tel 20. 00 Toi 21. 00 Uni	ministrative and General illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide pplies (see instructions) ugs E me Dialysis Aide Services spiratory Therapy ivate Duty Nursing inic allth Promotion Activities y Care Program me Delivered Meals Program memaker Service I Others (specify) lemedicine tal (sum of lines 1-19) (2) it Cost Multiplier: column , line 1 divided by the sum column 26, line 20 minus lumn 26, line 1, rounded to decimal places.	7, 096 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	965, 054 718, 909 75, 157 23, 798 13, 902 7, 631	0 0 0 0 0 0 0 0 0 0	317, 202 965, 054 718, 909 75, 157 23, 798 13, 902 7, 631 43, 491 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

					5/22/2024 9:5	4 aiii
				Home Health	PPS	
				Agency I		
	Cost Center Description	Allocated HHA	Total HHA			
		A&G (see Part	Costs			
		11)				
		27. 00	28. 00			
1.00	Administrative and General					1. 00
2.00	Skilled Nursing Care	164, 843	1, 129, 897			2. 00
3.00	Physical Therapy	122, 798	841, 707			3. 00
4.00	Occupational Therapy	12, 838	87, 995			4. 00
5.00	Speech Pathology	4, 065	27, 863			5. 00
6.00	Medical Social Services	2, 375	16, 277			6. 00
7.00	Home Health Aide	1, 303	8, 934			7. 00
8.00	Supplies (see instructions)	7, 429	50, 920			8. 00
9.00	Drugs	o	0			9. 00
10.00	DME	0	0			10.00
11. 00	Home Dialysis Aide Services	0	0			11. 00
12.00	Respiratory Therapy	0	0			12. 00
13.00	Private Duty Nursing	0	0			13. 00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15. 00
16.00	Day Care Program	0	0			16. 00
17.00	Home Delivered Meals Program	0	0			17. 00
18.00	Homemaker Service	0	0			18. 00
19.00	All Others (specify)	1, 551	10, 629			19. 00
19. 50	Tel emedi ci ne	0	0			19. 50
20.00	Total (sum of lines 1-19) (2)	317, 202	2, 174, 222			20.00
21.00	Unit Cost Multiplier: column	0. 170812				21.00
	26, line 1 divided by the sum					
	of column 26, line 20 minus					
	column 26, line 1, rounded to					
	6 decimal places.					

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Peri od: Worksheet H-2
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am

Home Heal th PPS BASIS HHA CCN: 14-7299 Home Health

						Home Health	PPS	
		CAPI	TAL RELATED CO	OSTS		Agency I		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI	
		1.00	1. 01	2.00	4. 00	5. 01	5. 02	
1.00	Administrative and General	3, 396	C	24, 992	171, 900		5	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	412 51 26 111 0 8 0 0 0		0 0	0	2 1 0 0 0 0 0 0 0	5 1 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
13.00	Private Duty Nursing	0	C	0	0	0	0	13.00
14. 00 15. 00 16. 00 17. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0	0 0 0	0 0	0 0	0	0 0 0	14. 00 15. 00 16. 00 17. 00
18. 00	Homemaker Service	l o	C	o o	ĺ		o	18. 00
19.00	All Others (specify)	o	C	0	0	2	2	19. 00
19. 50	Tel emedi ci ne	0	C	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19)	3, 904	C	24, 992			13	20.00
21. 00	Total cost to be allocated	47, 495	C	25, 518			46, 135	
22. 00	Unit cost multiplier	12. 165727	0.000000		0. 291916 OPERATION OF		3, 548. 846154	22. 00
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS REVE NUE)		AND GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
1 00	Administratives and Consent	5. 03	5A. 04	5. 04	7. 00	8. 00	9. 00	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	C	136, 578 866, 999			2, 772 412	1. 00 2. 00
3.00	Physical Therapy	0	C	656, 116			51	3. 00
4. 00	Occupational Therapy	O	C	67, 764			26	4. 00
5.00	Speech Pathology	0	C	21, 346	11	0	11	5.00
6.00	Medical Social Services	0	C	12, 727	0		0	6. 00
7.00	Home Heal th Ai de	0	C	6, 666			8	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	C	39, 816	0		0	8. 00 9. 00
10.00	DME	0		0			0	10.00
11. 00	Home Dialysis Aide Services	l ő	C	j ő			o	11. 00
12. 00	Respi ratory Therapy	o	C	0	0	0	0	12.00
13. 00	Private Duty Nursing	0	C	0	0	0	0	13.00
14.00	Clinic	0	C	0	0	0	0	14. 00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	C	0	0		0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0			_	0	17. 00
18. 00	Homemaker Service	ő	C	ő	ĺ		Ö	18. 00
19. 00	All Others (specify)	0	C	8, 311	0	0	0	19.00
19. 50	Tel emedi ci ne	0	C	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	0		1, 816, 323				20.00
21. 00 22. 00	Total cost to be allocated Unit cost multiplier	0. 000000		167, 654 0. 092304			35, 641 10. 866159	

HHA CCN:

							5/22/2024 9:5	4 am
						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS SERVED)	(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SERVI CE)		SUPPLY	REQUIS.)	LI BRARY	
				(DIRECT NRSING	(COSTED		(GROSS REVE	
				HR)	REQUIS.)		NUE)	
		10.00	11. 00	13.00	14.00	15. 00	16.00	
1.00	Administrative and General	0	7, 654		3, 69	0 0	1, 475, 474	1. 00
2.00	Skilled Nursing Care	0	. 0			0	1 0	2. 00
3.00	Physical Therapy	0	0			o o	0	3. 00
4. 00	Occupational Therapy		0			0 0	0	4. 00
5. 00	Speech Pathology		0			0 0		5. 00
6.00	Medical Social Services	0	0			0 0	0	6.00
	II	0	-	-			_	
7.00	Home Heal th Ai de	0	0	-		0		7. 00
8. 00	Supplies (see instructions)	0	0			0	0	8. 00
9.00	Drugs	0	0	-		0		9. 00
10. 00	DME	0	0	-		0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	-		0	0	11. 00
12.00	Respiratory Therapy	0	0	0		0	0	12. 00
13.00	Private Duty Nursing	0	0	0		0	0	13.00
14.00	Clinic	0	0	0		0 0	0	14.00
15.00	Health Promotion Activities	o	0	0		0 0	0	15. 00
16.00	Day Care Program	ol	0	0		o o	0	16. 00
17.00	Home Delivered Meals Program	o	0	0		0 0	l 0	17. 00
18. 00	Homemaker Service	0	0	0		0	0	18. 00
19. 00	All Others (specify)	0	0			o o	0	19.00
19. 50	Tel emedi ci ne		0	1		o o	ا م	19. 50
20. 00	Total (sum of lines 1-19)		7, 654	1			1, 475, 474	
21. 00	Total cost to be allocated		12, 311		6, 80		7, 096	
22. 00	Unit cost multiplier	0. 000000	1. 608440					
22.00	Cost Center Description	SOCI AL SERVI CE		0.00000	1.04300	7 0.000000	0.004007	22.00
	cost center bescription	SOUTHE SERVICE	ANESTHETI STS					
		(TIME SPENT)	(ASSI GNED					
		(TIME SIENT)	TIME)					
		17. 00	19. 00					
1. 00	Administrative and General	0	0					1. 00
2. 00	Skilled Nursing Care		0	l .				2. 00
3.00	Physical Therapy		0	•				3. 00
4. 00	Occupati onal Therapy		0	l .				4. 00
		0	0	l .				
5.00	Speech Pathology		0	l .				5. 00
6.00	Medical Social Services	0		l .				6.00
7.00	Home Heal th Ai de	0	0	l .				7. 00
8. 00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10. 00	DME	0	0					10. 00
11. 00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respiratory Therapy	0	0	l .				12. 00
13.00	Private Duty Nursing	0	0					13. 00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15. 00
16.00	Day Care Program		0					16. 00
17.00	Home Delivered Meals Program	o	0					17. 00
18. 00	Homemaker Service	l	0					18. 00
19. 00	All Others (specify)		0					19. 00
19. 50	Tel emedi ci ne		0					19. 50
20. 00	Total (sum of lines 1-19)		0					20. 00
21. 00	Total cost to be allocated		0					21. 00
	Unit cost multiplier	0. 000000	0. 000000	l .				22. 00
00	1	1 0.00000	3. 555666	1				

Heal th	Financial Systems		PANA COMMUNIT	LY HUSDI TVI		In lie	eu of Form CMS-2	2552_10
	TONMENT OF PATIENT SERVICE COST	S	PANA COMMUNIT		CN: 14-1341	Peri od:	Worksheet H-3	
7.11 0111	TOTAL OF THE ENT CENTREE SEC.					From 01/01/2023	Part I	
				HHA CCN:	14-7299	To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
				Ti tl e	e XVIII	Home Health	PPS	4 аш
						Agency I		
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
		COI . 20, TTHE	п-2, Рап (I)	Part II)	+ 2)		4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation	1						
1.00	Skilled Nursing Care	2.00		_	1, 129, 89			1.00
2.00	Physical Therapy Occupational Therapy	3.00			1 ,			•
3. 00 4. 00	Speech Pathology	4. 00 5. 00			87, 99 27, 80			•
5. 00	Medical Social Services	6. 00			16, 2		602. 85	
6. 00	Home Heal th Aide	7. 00			8, 93			1
7. 00	Total (sum of lines 1-6)	7.00	2, 112, 673	(2, 112, 6			7. 00
7.00	Total (Sam of Filles 1 o)		2,112,070		Program Visi			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	to Subject to		
					Deductibles			
					Coi nsurance			
		0	1. 00	2. 00	3.00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	I	99914	(1, 3!	52	I	8.00
8. 01	Skilled Nursing Care		41180			14		8. 01
9. 00	Physical Therapy		99914		1			9. 00
9. 01	Physical Therapy		41180	Č	30			9. 01
10.00	Occupational Therapy		99914	Č	28			10.00
10. 01	Occupational Therapy		41180	C	1			10. 01
11.00	Speech Pathology		99914	C) :	36		11. 00
11. 01	Speech Pathology		41180	C		8		11. 01
12.00	Medical Social Services		99914	C)	11		12. 00
12. 01	Medical Social Services		41180	C		5		12. 01
13. 00	4		99914	C	1	13		13. 00
13. 01	Home Health Aide		41180	C	l .	14		13. 01
14. 00	Total (sum of lines 8-13)	- "		0	4, 08		D 11 (1 0	14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11116	п-2, Pai (I)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa							
15.00	Cost of Medical Supplies	8. 00		C	50, 92	20 49, 972	1. 018971	15. 00
16. 00	Cost of Drugs	9. 00		C)	0 0	0. 000000	16. 00
			Program Visits		Cost of			
			-		Servi ces	D 1 D		
	Coot Contan Decemention	Don't A	Par		Don't A	Part B Not Subject to	Cubi cot to	
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	.,			0 471, 084		1.00
2.00	Physical Therapy	0	_, -,			0 456, 692		2.00
3.00	Occupational Therapy	0	401			0 48, 874		3.00
4.00	Speech Pathology	0	44			0 16, 567		4.00
5. 00 6. 00	Medical Social Services Home Health Aide		16 27			0 9, 646 0 12, 696		5. 00 6. 00
7. 00	Total (sum of lines 1-6)		1			0 1, 015, 559		7.00
, . 50	1.0107 (3011 01 111103 1 0)	1	1 7,000		1	1,015,557	I	, , , , ,

Heal th	Financial Systems		PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 14-1341	Peri od: From 01/01/2023	Worksheet H-3 Part I	3
				HHA CCN:	14-7299	To 12/31/2023		
				Ti tl e	e XVIII	Home Health Agency I	PPS	- T - G.III
	Cost Center Description	4.00	7.00	0.00	0.00		11 00	
	Limitation Cost Computation	6. 00	7. 00	8.00	9. 00	10. 00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01
14. 00	Total (sum of lines 8-13)	Prog	 ram Covered Cha	race	Cost of			14. 00
		Prog		t B	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	8, 693	О		0 8, 858	C	15.00
	Cost of Drugs		0,073	l		0,030		
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OF	?	
1.00	Skilled Nursing Care	471, 084						1.00
2.00	Physi cal Therapy	456, 692						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology	48, 874 16, 567						3. 00 4. 00
5.00	Medical Social Services	9, 646						5. 00
6.00	Home Health Aide	12, 696						6.00
7. 00	Total (sum of lines 1-6)	1, 015, 559						7. 00
	Cost Center Description	12. 00						-
	Limitation Cost Computation	12.00						
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 01 12. 00 12. 01 13. 00
13. 01	Home Health Aide Home Health Aide Total (sum of lines 8-13)							13. 13. 14.

Heal th	Financial Systems		PANA COMMUNIT	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APP0R	FIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	14-7299	From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	pared:
							5/22/2024 9: 54	
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		l
1.00	Physi cal Therapy	66. 00	0. 460198	0)	0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 136902	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 301007	0)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems PANA COMMUNITY ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CO	CN: 14-1341	Peri od:		u of Form CMS-2 Worksheet H-4	
		HHA CCN:	14-7299	From 01/01/2 To 12/31/2		Part I-II Date/Time Pre	pare
		Title	XVIII	Home Healt Agency I	h	5/22/2024 9: 5 PPS	<u>4 ar</u>
						t B	
			Part A		s &	Deductibles &	
			1.00	Coi nsurano 2. 00	ce	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	OMARY CHARGE		2.00		0.00	
	Reasonable Cost of Part A & Part B Services			0	0	0	١,
)O)O	Reasonable cost of services (see instructions) Total charges			0	0	0	
	Customary Charges						
0	Amount actually collected from patients liable for payment fo	r services		0	0	0	3
0	on a charge basis (from your records) Amount that would have been realized from patients liable for	payment		0	0	0	_
	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)					-	
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0.000	0000	0. 000000	
10 10	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0	0	0	
,0	only if line 6 exceeds line 1)	(comprete		o e	U	U	
00	Excess of reasonable cost over customary charges (complete on	lyifline		0	0	0	8
00	1 exceeds line 6) Primary payer amounts			0	0	0	,
				Part A	-	Part B	
				Servi ces 1.00	;	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00		2.00	
00	Total reasonable cost (see instructions)				0	0	
00	Total PPS Reimbursement - Full Episodes without Outliers				0	778, 900	
00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0	66, 020 10, 551	
00	Total PPS Reimbursement - PEP Episodes				0	1, 617	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	13, 346	
00	Total PPS Outlier Reimbursement - PEP Episodes				0	403	
00	Total Other Payments				0	0	
00	DME Payments Oxygen Payments				0	0	1
00	Prosthetic and Orthotic Payments				0	0	
00	Part B deductibles billed to Medicare patients (exclude coins	urance)				0	2
00	Subtotal (sum of lines 10 thru 20 minus line 21)				0	870, 837	
00	Excess reasonable cost (from line 8)				0	070.027	1
00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				U	870, 837 0	1 .
00	Net cost (line 24 minus line 25)				n	870, 837	
	Allowable bad debts (from your records)				Ŭ	0	1
01	Adjusted reimbursable bad debts (see instructions)					0	2
00	Allowable bad debts for dual eligible (see instructions)				_	0	
00	Total costs - current cost reporting period (see instructions))			0	870, 837	
00 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	5)			0	0	
99	Demonstration payment adjustment amount before sequestration	<u>-,</u>			0	0	
00	Subtotal (see instructions)				0	870, 837	
01	Sequestration adjustment (see instructions)				0	17, 416	
02	Demonstration payment adjustment amount after sequestration				0	0	
75	Sequestration adjustment for non-claims based amounts (see in	structions)			0	0 952 421	
00	Interim payments (see instructions)				0	853, 421 0	1
	Tentative settlement (for contractor use only)				U		
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.0	2 31 75 32	and 33)		(1)	0	34

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED

TO PROGRAM BENEFICIARIES

PANA COMMUNITY HOSPITAL
Provider
Provider Peri od: Worksnee: ...
From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 5/22/2024 9:54 am
PPS Provider CCN: 14-1341 HHA CCN: 14-7299

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4.00	
1. 00 2. 00	Total interim payments paid to provider 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	853, 421 0	1. 00 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) Program to Provider					3. 00
3. 01			(O	0	3. 01
3. 02			(Ö	0	3. 02
3.03				O	0	3. 03
3.04				0	0	3. 04
3. 05			(O	0	3. 05
2 50	Provider to Program				0	2 50
3. 50 3. 51				0	0	3. 50 3. 51
3. 52				0		3. 52
3.53				Ö	Ö	3. 53
3.54				Ö	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		(0	853, 421	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				O	0	5. 01
5. 02				O	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	Frovider to Frogram			o	0	5. 50
5. 51				o O	o o	5. 51
5. 52			(Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(ס	0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROCEDUM			0	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program Liability (see instructions)			0	0 853, 421	6. 02 7. 00
7.00	Total Medicare program liability (see instructions)		'	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.00
8. 00	Name of Contractor			1	ı l	8. 00

Provider CCN: 14-1341 Peri od: Worksheet 0 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Hospi ce CCN: 14-1575

			_			3/22/2024 9.3	T CIII
		0.11.451.50	OTUED.	OUDTOTAL (Hospi ce I	OUDTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00		1 plus col. 2)	CATI ONS		
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVI CE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	82, 354	100, 968	183, 322	0	183, 322	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	O	4, 442	4, 442	0	4, 442	5. 00
6.00	LAUNDRY & LINEN SERVICE*	ol	. 0	0	0	0	6. 00
7. 00	HOUSEKEEPI NG*	ام	0	0	0	0	7. 00
8. 00	DI ETARY*		0	o o	0	0	8. 00
9. 00	NURSING ADMINISTRATION*		0	0	0	0	9. 00
			0	0	0		
10.00	ROUTINE MEDICAL SUPPLIES*		0	0	0	0	10.00
11. 00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	0	0	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13. 00
14.00	PHARMACY*	0	0	0	0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	o	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	8, 246	0	8, 246	0	8, 246	26. 00
27. 00	NURSE PRACTITIONER**	0, 240	0	0, 240	0	0, 240	27. 00
	REGISTERED NURSE**	114 520	0	114 520	0	_	
28. 00		114, 530	0	114, 530	0	114, 530	28. 00
29. 00	LPN/LVN**	33, 559	0	33, 559	0	33, 559	29. 00
30. 00	PHYSI CAL THERAPY**	273	0	273	0	273	30. 00
31. 00	OCCUPATI ONAL THERAPY**	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES**	47, 752	0	47, 752	0	47, 752	33. 00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG**	O	0	0	0	0	35. 00
36.00	COUNSELING - OTHER**	O	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	59, 103	0	59, 103	0	59, 103	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0.,	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**		0	o o	0	0	39. 00
40. 00	IMAGING SERVICES**		0	0	0	0	40. 00
41. 00			0	0	0	0	
	LABS & DI AGNOSTI CS**		TO 222	50.000	U	TO 200	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	58, 329		0	58, 329	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0	22, 955	22, 955	0	22, 955	42. 50
43. 00	OUTPATI ENT SERVI CES**	0	0	0	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62. 00	FUNDRAI SI NG*		0	i o	0	Ö	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0	o o	0	0	63. 00
	PALLIATIVE CARE PROGRAM*		0	0	0	0	64. 00
64. 00			0	0	0	_	
65. 00	OTHER PHYSICIAN SERVICES*		0	0	0	0	65. 00
66. 00	RESI DENTI AL CARE*	0	0	0	0	0	66. 00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	68. 00
69. 00	THRI FT STORE*	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	3, 748		0	3, 748	71. 00
100.00	TOTAL	345, 817	190, 442	536, 259	0	536, 259	100.00
- T	6 11 1 7 1 11 0 5						

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ADJUSTMENTS TOTAL (col. 5 ± col. 6)	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00
± col. 6) 6.00 7.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
GENERAL SERVICE COST CENTERS	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT* 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 CAP REL COSTS-MVBLE EQUIP* 3. 00 EMPLOYEE BENEFITS DEPARTMENT* 4. 00 ADMI NI STRATI VE & GENERAL* 5. 00 PLANT OPERATION & MAINTENANCE* 6. 00 LAUNDRY & LI NEN SERVI CE* 7. 00 HOUSEKEEPI NG* 9. 00 DI ETARY* 9. 00 NURSI NG ADMI NI STRATI ON* 10. 00 ROUTI NE MEDI CAL SUPPLIES* 11. 00 MEDI CAL RECORDS* 12. 00 STAFF TRANSPORTATI ON* 13. 00 VOLUNTEER SERVI CE COORDI NATI ON* 14. 00 PHARMACY* 15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES*	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4. 00 ADMINISTRATIVE & GENERAL* 0 183, 322 5. 00 PLANT OPERATION & MAINTENANCE* 0 4, 442 6. 00 LAUNDRY & LINEN SERVICE* 0 0 7. 00 HOUSEKEEPING* 0 0 8. 00 DIETARY* 0 0 9. 00 NURSING ADMINISTRATION* 0 0 10. 00 ROUTINE MEDICAL SUPPLIES* 0 0 11. 00 MEDICAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATION* 0 0 13. 00 VOLUNTEER SERVICE COORDINATION* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
5. 00 PLANT OPERATION & MAINTENANCE* 0 4, 442 6. 00 LAUNDRY & LINEN SERVICE* 0 0 7. 00 HOUSEKEEPING* 0 0 8. 00 DI ETARY* 0 0 9. 00 NURSING ADMINISTRATION* 0 0 10. 00 ROUTINE MEDICAL SUPPLIES* 0 0 11. 00 MEDICAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATION* 0 0 13. 00 VOLUNTEER SERVICE COORDINATION* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
6. 00	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7. 00	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
8. 00 DI ETARY* 0 0 0 9. 00 NURSI NG ADMI NI STRATI ON* 0 0 10. 00 ROUTI NE MEDI CAL SUPPLI ES* 0 0 11. 00 MEDI CAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATI ON* 0 0 13. 00 VOLUNTEER SERVI CE COORDI NATI ON* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES* 0 0	8. 00 9. 00 10. 00 11. 00 12. 00
9. 00 NURSI NG ADMI NI STRATI ON* 0 0 10. 00 ROUTI NE MEDI CAL SUPPLI ES* 0 0 11. 00 MEDI CAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATI ON* 0 0 13. 00 VOLUNTEER SERVI CE COORDI NATI ON* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES* 0 0	9. 00 10. 00 11. 00 12. 00
10. 00 ROUTI NE MEDI CAL SUPPLI ES* 0 0 11. 00 MEDI CAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATI ON* 0 0 13. 00 VOLUNTEER SERVI CE COORDI NATI ON* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES* 0 0	10. 00 11. 00 12. 00
11. 00 MEDI CAL RECORDS* 0 0 12. 00 STAFF TRANSPORTATI ON* 0 0 13. 00 VOLUNTEER SERVI CE COORDI NATI ON* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES* 0 0	11. 00 12. 00
12. 00 STAFF TRANSPORTATION* 0 0 13. 00 VOLUNTEER SERVICE COORDINATION* 0 0 14. 00 PHARMACY* 0 0 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0	12.00
14. 00 PHARMACY*	1 1 2 0
15. 00 PHYSI CI AN ADMINI STRATI VE SERVI CES* 0 0	13.00
	14. 00
	15. 00
16. 00 OTHER GENERAL SERVICE*	16. 00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES	17.00
DI RECT PATIENT CARE SERVICE COST CENTERS	ا م
25. 00 I NPATI ENT CARE-CONTRACTED** 1, 878 1, 878 26. 00 PHYSI CI AN SERVI CES** 0 8, 246	25. 00
26. 00 PHYSICIAN SERVICES**	26. 00 27. 00
28. 00 REGI STERED NURSE** 0 114, 530	28.00
29. 00 LPN/LVN** 0 33, 559	29.00
30. 00 PHYSI CAL THERAPY** 0 273	30.00
31. 00 OCCUPATI ONAL THERAPY**	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY** 0 0	32.00
33.00 MEDICAL SOCIAL SERVICES** 0 47,752	33. 00
34. 00 SPIRITUAL COUNSELING**	34.00
35. 00 DI ETARY COUNSELI NG**	35. 00
36. 00 COUNSELING - OTHER**	36.00
37. 00 HOSPICE ALDE & HOMEMAKER SERVICES** 0 59, 103	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 39. 00 PATIENT TRANSPORTATION** 0 0	38.00
40. 00 IMAGING SERVI CES**	40.00
41. 00 LABS & DI AGNOSTI CS**	41. 00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 58, 329	42. 00
42. 50 DRUGS CHARGED TO PATIENTS** 0 22, 955	42. 50
43. 00 OUTPATIENT SERVICES**	43.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0	45. 00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0	46. 00
NONREI MBURSABLE COST CENTERS	4
60. 00 BEREAVEMENT PROGRAM * 0 0	60.00
61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00
62. 00 FUNDRAI SI NG*	62.00
64. 00 PALLIATIVE CARE PROGRAM*	64.00
65. 00 OTHER PHYSI CI AN SERVI CES*	65.00
66. 00 RESI DENTI AL CARE*	66. 00
67. 00 ADVERTI SING* 0 0	67. 00
68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0	68. 00
69. 00 THRI FT STORE* 0 0	69.00
70.00 NURSING FACILITY ROOM & BOARD* 0 0	70.00
71. 00 OTHER NONREIMBURSABLE (SPECIFY)* 0 3,748	
100. 00 TOTAL 1, 878 538, 137	71. 00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Hospi ce CCN:

0

0

0

Peri od: From 01/01/2023 То 12/31/2023

Date/Time Prepared:

0 46.00

0 100.00

14-1575 5/22/2024 9:54 am Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL CATI ONS 1 + col. 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 26.00 0 26.00 0 NURSE PRACTITIONER 0 27.00 27.00 0 0 28.00 REGISTERED NURSE 0 0 28.00 29.00 LPN/LVN 0 29.00 0 0 30.00 PHYSI CAL THERAPY 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 31.00 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 0 33.00 SPIRITUAL COUNSELING 0 34.00 0 0 34.00 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 37.00 37.00 0 0 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38.00 38.00 0 0 39.00 PATIENT TRANSPORTATION 0 0 39.00 40.00 I MAGING SERVICES 40.00 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 0 43.00 43.00 0 0 PALLIATIVE RADIATION THERAPY 0 44.00 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 45.00

0

OTHER PATIENT CARE SERVICES (SPECIFY)

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			1
25.00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	0	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	0	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

46.00

100.00 TOTAL *

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Hospi ce CCN: 14-1575

Peri od: Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Worksheet 0-2

					5/22/2024 9:5	4 am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col. 2)	CATI ONS		
	1.00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 INPATIENT CARE-CONTRACTED						25. 00
26. 00 PHYSI CI AN SERVI CES	8, 230	0	8, 230	0	8, 230	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	114, 311	0	114, 311	0	114, 311	28. 00
29. 00 LPN/LVN	33, 495	0	33, 495	0	33, 495	29. 00
30. 00 PHYSI CAL THERAPY	272	0	272	0	272	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	47, 661	0	47, 661	0	47, 661	33. 00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	58, 990	0	58, 990	0	58, 990	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 I MAGING SERVICES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	58, 217	58, 217	0	58, 217	42. 00
42.50 DRUGS CHARGED TO PATIENTS	0	22, 911	22, 911	0	22, 911	42. 50
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	
100. 00 TOTAL *	262, 959	81, 128	344, 087	0	344, 087	100.00
* Transfer the amount in column 7 to Wkst 0-5 co	dumn 1 line 51					

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

		AD ILICTATATO	TOTAL (L E	
		ADJUSTMENTS	TOTAL (col. 5	
		6, 00	± col . 6)	
	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00	7.00	_
25. 00		I	T T	25. 00
	I NPATI ENT CARE-CONTRACTED		0.000	
26. 00	PHYSI CI AN SERVI CES	0	8, 230	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	114, 311	28. 00
29. 00	LPN/LVN	0	33, 495	29. 00
30. 00	PHYSI CAL THERAPY	0	272	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	47, 661	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	0	34. 00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	58, 990	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	l ol	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	58, 217	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	22, 911	42. 50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	l ol	44.00
45. 00	PALLIATIVE CHEMOTHERAPY	0	l	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	l	46. 00
100.00	TOTAL *	0	344, 087	100.00

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Hospi ce CCN: 14-1575 Peri od: Worksheet 0-3 From 01/01/2023 То 12/31/2023 Date/Time Prepared:

5/22/2024 9:54 am Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL CATI ONS 1 + col.1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 PHYSICIAN SERVICES 26.00 16 0 16 16 26.00 NURSE PRACTITIONER 27.00 0 0 0 27.00 0 28.00 REGISTERED NURSE 219 0 219 219 28.00 29.00 LPN/LVN 29.00 64 64 64 30.00 PHYSI CAL THERAPY 1 0 1 30.00 1 OCCUPATIONAL THERAPY 0 0 31.00 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 91 91 33.00 SPIRITUAL COUNSELING 0 34.00 0 0 0 34.00 0 35.00 DIETARY COUNSELING 0 0 35.00 0 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 113 0 0 37.00 37.00 113 113 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38.00 38.00 0 0 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 0 39.00 40.00 I MAGING SERVICES 40.00 0 0 LABS & DIAGNOSTICS 41.00 0 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 42.00 112 112 112 42.00 42.50 DRUGS CHARGED TO PATIENTS 44 44 44 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 0 46.00 100.00 TOTAL * 504 660 100.00 156 660

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

			1	
		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			4
25. 00	I NPATIENT CARE-CONTRACTED	1, 878	1, 878	25. 00
26. 00	PHYSI CI AN SERVI CES	0	16	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	219	28. 00
29.00	LPN/LVN	0	64	29. 00
30.00	PHYSI CAL THERAPY	0	1	30.00
31.00	OCCUPATI ONAL THERAPY	0	o	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	91	33.00
34.00	SPIRITUAL COUNSELING	0	ol	34.00
35. 00	DI ETARY COUNSELI NG	0	ol	35. 00
36.00	COUNSELING - OTHER	0	l ol	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	113	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	ol	38. 00
39. 00	PATIENT TRANSPORTATION	0	o	39.00
40. 00	I MAGING SERVICES	0	o	40.00
41. 00	LABS & DI AGNOSTI CS	0	o	41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE	0	112	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	44	42. 50
43. 00	OUTPATIENT SERVICES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY			44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	1	ا	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)			46.00
	TOTAL *	1, 878	2, 538	100.00
. 50. 00	1.0	1,070	2,000	1.00.00

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

Heal th	Financial Systems PANA COMMUNIT	Y HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 14-1341	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION	Hospi ce CCI	N: 14-1575	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
				Hospi ce I	0,22,2021 7.0	ı uıı
	Descriptions	<u> </u>	HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			instructions		1 + 2)	
				WKST B PART I		
				(see instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVI CE COST CENTERS		1.00	2.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 6, 990	6, 990	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 100, 950	100, 950	3. 00
4.00	ADMINISTRATIVE & GENERAL		183, 32	148, 263	331, 585	4. 00
5.00	PLANT OPERATION & MAINTENANCE		4, 4	12 0	4, 442	5. 00
6.00	LAUNDRY & LINEN SERVICE			0	0	6. 00
7. 00	HOUSEKEEPING			0	0	7. 00
8. 00	DI ETARY			0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON			0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 273 0 4, 079		
11. 00 12. 00	MEDICAL RECORDS STAFF TRANSPORTATION			4,079	4, 079 0	11. 00 12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			0	0	
14. 00	PHARMACY			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	Ö	15.00
16. 00	OTHER GENERAL SERVICE			0 0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPI CE CONTINUOUS HOME CARE			0	0	50.00
51. 00	HOSPI CE ROUTI NE HOME CARE		344, 08		344, 087	
52. 00	HOSPICE INPATIENT RESPITE CARE		2, 53		2, 538	
53. 00	HOSPICE GENERAL INPATIENT CARE			0	0	53. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM		T	0	0	60.00
61. 00	VOLUNTEER PROGRAM			0	0	61.00
62. 00	FUNDRAI SI NG			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM			ő	0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES			0	Ö	65. 00
66. 00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67. 00
68 00	TELEHEALTH/TELEMONI TORLING		1		1 0	68 00

68. 00

69. 00 70. 00

71.00

0

798, 692 100. 00

3, 748 0 99. 00

538, 137

260, 555

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69.00 THELEHEALTH/TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

Heal th FinancialSystemsPANA COMMUCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-1341 | Peri od: From 01/01/2023 | Part I |
Hospice CCN: 14-1575 | To 12/31/2023 | Date/Time Prepared: 5/22/2024 9:54 am

Descriptions
FIX EQUIP BENEFITS DEPARTMENT D DEPARTMENT D DEPARTMENT D DEPARTMENT D D D D D D D D D
FIX EQUIP BENEFITS DEPARTMENT D DEPARTMENT D DEPARTMENT D DEPARTMENT D D D D D D D D D
CAP REL COSTS-BLDG & FIXT O O O O O O O O O
O
CAP REL COSTS-BLDG & FIXT
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 6, 990 6, 990 2. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 6, 990 6, 990 6, 990 2. 00 3. 00 EMPLOYEE BENEFITS DEPARTMENT 100, 950 0 0 100, 950 3. 00 4. 00 ADMI NI STRATI VE & GENERAL 331, 585 0 6, 990 24, 041 362, 616 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 4, 442 0 0 0 0 4, 442 0 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 6.00 7. 00 HOUSEKEEPI NG 0 <t< td=""></t<>
2. 00 CAP REL COSTS-MVBLE EQUI P 6,990 6,990 2. 00 3. 00 EMPLOYEE BENEFITS DEPARTMENT 100,950 0 0 100,950 3. 00 4. 00 ADMI NI STRATI VE & GENERAL 331,585 0 6,990 24,041 362,616 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 4,442 0 0 0 0 4,442 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0 0 0 0 7. 00 8. 00 DI ETARY 0 0 0 0 0 0 0 0 0 0 0 0 9. 00 9. 00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 0 0 0 0 9. 00 10. 00 ROUTI INE MEDI CAL SUPPLIES 273 0 0 0 273 10. 00 12. 00 STAFF TRANSPORTATI ON 0 0 0 0 0 0 0 12. 00
3.00 EMPLOYEE BENEFITS DEPARTMENT 100, 950 0 0 100, 950 3.00 4.00 ADMI NI STRATI VE & GENERAL 331, 585 0 6, 990 24, 041 362, 616 4.00 5.00 PLANT OPERATI ON & MAI NTENANCE 4, 442 0 0 0 0 0 4, 442 5.00 6.00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
4. 00 ADMI NI STRATI VE & GENERAL 331, 585 0 6, 990 24, 041 362, 616 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 4, 442 0 0 0 4, 442 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0
5. 00 PLANT OPERATION & MAINTENANCE 4,442 0 0 0 4,442 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 6. 00 7. 00 HOUSEKEEPI NG 0 0 0 0 0 0 0 7. 00 8. 00 DI ETARY 0 0 0 0 0 0 0 8. 00 9. 00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 0 9. 00 10. 00 ROUTI NE MEDI CAL SUPPLI ES 273 0 0 0 273 10. 00 11. 00 MEDI CAL RECORDS 4, 079 0 0 0 4, 079 11. 00 12. 00 STAFF TRANSPORTATI ON 0 0 0 0 0 12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 0 0 0 0 0 14. 00
6. 00 LAUNDRY & LI NEN SERVI CE
7. 00 HOUSEKEEPING 0 0 0 0 0 7. 00 8. 00 DI ETARY 0 0 0 0 0 0 8. 00 9. 00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 0 9. 00 10. 00 ROUTI NE MEDI CAL SUPPLI ES 273 0 0 0 273 10. 00 11. 00 MEDI CAL RECORDS 4, 079 0 0 0 4, 079 11. 00 12. 00 STAFF TRANSPORTATI ON 0 0 0 0 0 12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 0 0 0 13. 00 14. 00 PHARMACY 0 0 0 0 0 0 14. 00
8.00 DI ETARY 0 0 0 0 0 0 8.00 9.00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 9.00 10.00 ROUTI NE MEDI CAL SUPPLI ES 273 0 0 0 273 10.00 11.00 MEDI CAL RECORDS 4,079 0 0 0 4,079 11.00 12.00 STAFF TRANSPORTATI ON 0 0 0 0 12.00 13.00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 0 14.00
9.00 NURSING ADMINISTRATION 0 0 0 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 273 0 0 0 273 10.00 11.00 MEDICAL RECORDS 4,079 0 0 0 4,079 11.00 12.00 STAFF TRANSPORTATION 0 0 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 0 14.00
10.00 ROUTINE MEDICAL SUPPLIES 273 0 0 0 273 10.00 11.00 MEDICAL RECORDS 4,079 0 0 0 4,079 11.00 12.00 STAFF TRANSPORTATION 0 0 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 14.00
11. 00 MEDI CAL RECORDS 4,079 0 0 4,079 11. 00 12. 00 STAFF TRANSPORTATION 0 0 0 0 0 12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATION 0 0 0 0 0 13. 00 14. 00 PHARMACY 0 0 0 0 0 14. 00
12.00 STAFF TRANSPORTATION 0 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 14.00
13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 14.00
14.00 PHARMACY 0 0 0 0 14.00
15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 0 0 15. 00
16. 00 OTHER GENERAL SERVICE 0 0 0 16. 00
17. 00 PATIENT/RESI DENTI AL CARE SERVI CES 0 0 0 17. 00
LEVEL OF CARE
50.00 HOSPICE CONTINUOUS HOME CARE 0 0 50.00
51. 00 HOSPICE ROUTINE HOME CARE 344, 087 76, 909 420, 996 51. 00
52.00 HOSPICE INPATIENT RESPITE CARE 2, 538 0 0 0 0 2, 538 52.00
53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 53.00
NONREI MBURSABLE COST CENTERS
60.00 BEREAVEMENT PROGRAM 0 0 0 0 0 60.00
61. 00 VOLUNTEER PROGRAM 0 0 0 0 0 61. 00
62. 00 FUNDRAI SI NG 0 0 0 0 62. 00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 0 0 63.00
64.00 PALLIATIVE CARE PROGRAM 0 0 0 0 64.00
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 65. 00
66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00
67. 00 ADVERTISING O O O O O 67. 00
68. 00 TELEHEALTH/TELEMONI TORING 0 0 0 68. 00
69. 00 THRIFT STORE 0 0 0 0 69. 00
70. 00 NURSI NG FACI LITY ROOM & BOARD 0 0 70. 00
71.00 OTHER NONREI MBURSABLE (SPECIFY) 3, 748 0 0 0 3, 748 71.00
99. 00 NEGATI VE COST CENTER 0 0 0 99. 00
100.00 TOTAL 798, 692 0 6, 990 100, 950 798, 692 100.00
1 175,572, 51 5,775, 105,700, 776,672,166.66

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-1341 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1575 12/31/2023 Date/Time Prepared: 5/22/2024 9:54 am Hospi ce I ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4.00 6.00 7. 00 8. 00 5.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 362, 616 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 3, 694 8. 136 5.00 LAUNDRY & LINEN SERVICE 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 0 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 9.00 0 9.00 0 ROUTINE MEDICAL SUPPLIES 0 10.00 227 10.00 11.00 MEDICAL RECORDS 3, 392 11.00 12.00 STAFF TRANSPORTATION 0 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 0 13.00 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 50.00 HOSPICE ROUTINE HOME CARE 350, 076 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 2, 110 8, 136 0 0 0 52.00 0 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 60 00 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0000000 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG Ω 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 C 69.00 NURSING FACILITY ROOM & BOARD

3.117

362, 616

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0

70.00

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0 99.00

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0

70.00

71 00

100.00 TOTAL

OTHER NONREIMBURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER

Provider CON: 14-1341 Peri od: Prom 01/01/2023 Part 1 Part	Heal th	Financial Systems	PANA COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Hospice CON. 14-1575 To 12/31/2023 Date/Time Prepared: S/22/2024 9:34 am Hospice CON. Ho	COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der CC	CN: 14-1341			
Descriptions				Hospi co CCN	J. 14 1575			narod:
NURSI NG ADMINISTRATI ON SERVICE SERVICE				nospi ce con	N. 14-15/5	10 12/31/2023	5/22/2024 9:5	pareu. 4 am
ADMINISTRATION MEDICAL RECORDS TRANSPORTATION CORPO INTO INC.						Hospi ce I		
SUPPLIES		Descriptions						
GENERAL SERVICE COST CENTERS			ADMI NI STRATI ON		RECORDS	TRANSPORTATI ON		
GENERAL SERVICE COST CENTERS			0.00		11 00	12.00		
1.00		CENEDAL SEDVICE COST CENTEDS	9.00	10.00	11.00	12.00	13.00	
2. 00 CAP REL COSTS-MVBLE EQUIP	1 00							1 00
3. 00 EMPLOYEE BENEFITS DEPARTMENT								1
5. 00 PLANT OPERATION & MAINTENANCE								•
6. 00 LAUNDRY & LINEN SERVICE	4.00	ADMINISTRATIVE & GENERAL						4. 00
7. 00 HOUSEKEEPING	5.00	PLANT OPERATION & MAINTENANCE						5. 00
8. 00 9. 00 NURSING ADMINISTRATION 0. 00 10. 00 ROUTI NE MEDI CAL SUPPLIES 0. 0500 11. 00 MEDI CAL RECORDS 0. 07, 471 11. 00 12. 00 13. 00 VOLUNTEER SERVICE COORDINATION 0. 00 14. 00 15. 00 PHARMACY 0. 00 16. 00 17. 471 0. 01 18. 00 19. 00 19. 00 19. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 471 0. 01 18. 00 19. 00 0. 01 19. 00 19. 00 0. 01 19. 00 10	6.00	I .						6. 00
9.00 NURSI ING ADMI NI STRATI ON 0 10.00								
10.00 ROUTINE MEDICAL SUPPLIES 0 500 1.1 00 1.1 00 1.1 00 MEDICAL RECORDS 0 7,471 1.1 00 1.1 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.2 00 1.3 00 1.2 00 1.3 00		I .						•
11. 00 MEDI CAL RECORDS 0 7, 471 11. 00 12. 00 13. 00 00 12. 00 13. 00 00 14. 00 00 12. 00 14. 00 00 00 00 00 00 00 00		1	0	F00				
12.00 STAFF TRANSPORTATION 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00 14.00 14.00 15.00 14.00 15.00 15.00 15.00 15.00 15.00 16.00 0 0 0 0 0 0 0 15.00 16.00 0 0 0 0 0 0 0 0 0		I .	0	500	7 /-	71		
13. 00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13. 00 14. 00 PHARMACY 0 0 0 0 0 14. 00 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 15. 00 16. 00 OTHER GENERAL SERVICE 0 0 0 0 16. 00 17. 00 PATI ENT/RESI DENTI AL CARE SERVICES 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 10. 00 THOURD HOME CARE 0 0 0 0 10. 00 THER PROGRAM 0 0 0 10. 00 THER PROGRAM 0 0 0 10. 00 THER PHYSICIAN SERVICES 0 0 0 10. 00 THOURD THER TORE 0 0 0 10. 00 THER NONREI MBURSABLE (SPECIFY) 0 0 0 10. 00 THER NONREI MBURSABLE (SPECIFY) 0 0 0 0 10. 00 THOURD THER TO THER TO THE TOTHER TO THE TO			0		7, 4	0		
14. 00 PHARMACY 15. 00 PHYSICI AN ADMINISTRATIVE SERVICES 0 0 0 16. 00 17. 00 DTHER GENERAL SERVICE 0 0 0 16. 00 17. 00 DTHER GENERAL SERVICES 0 0 0 0 16. 00 17. 00 LEVEL OF CARE 50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0 0 0 0 0 50. 00 51. 00 HOSPICE ROUTINE HOME CARE 0 0 499 7, 457 0 0 51. 00 52. 00 HOSPICE INPATIENT RESPITE CARE 0 0 1 1 14 0 0 52. 00 53. 00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 0 52. 00 53. 00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							0	1
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 16.00 17.00		· I	Ö			Ö		1
17. 00			0			0		
LEVEL OF CARE	16.00	OTHER GENERAL SERVICE	o			o	0	16. 00
50. 00	17. 00							17. 00
51. 00 HOSPI CE ROUTI NE HOME CARE 0 499 7, 457 0 0 51. 00 52. 00 HOSPI CE INPATI ENT RESPI TE CARE 0 1 14 0 0 52. 00 53. 00 HOSPI CE GENERAL I NPATI ENT CARE 0 0 0 0 0 53. 00 MONREI MBURSABLE COST CENTERS ***********************************								
1				0		9	_	
NORMEI MBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O			I	499	-			
NONREI MBURSABLE COST CENTERS O				1				
60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THIF FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 70. 00 NEGATI VE COST CENTER 70 O O O O O O O O O O O O O O O O O O O	33.00		<u> </u>	<u> </u>		<u>v </u>	0	33.00
61. 00 VOLUNTEER PROGRAM 0 0 0 61. 00 62. 00 FUNDRAI SI NG 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 71. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 99. 00	60.00		0			0	0	60 00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 68. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 0 99. 00		II .				O		•
64. 00 PALLIATIVE CARE PROGRAM 0 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 66. 00 67. 00 ADVERTISING 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 68. 00 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 0 0 0 99. 00	62.00	FUNDRAI SI NG	o			o	0	62. 00
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 66. 00 67. 00 ADVERTISING 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 68. 00 69. 00 THRIFT STO/TELEMONITORING 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 0 71. 00 99. 00 NEGATIVE COST CENTER 0 0 0 0 0 99. 00	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 68. 00 0 0 67. 00 68. 00 0 0 67. 00 68. 00 0 0 68. 00 0 0 68. 00 0 0 68. 00 0 0 69. 00 0 0 69. 00 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64.00		0			0	0	64. 00
67. 00 ADVERTISING 0 0 67. 00 68. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0			0			0		•
68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 68. 00 69. 00 THRI FT STORE 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 0 0 0 99. 00			0			0		•
69. 00		I .	0			0		1
70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00		I .	0			0		•
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00						١	Ü	1
99.00 NEGATIVE COST CENTER 0 0 0 0 99.00			0			0	n	•
		1	1	n				1
				500	7, 4	71 0		•

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-1341 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1575 12/31/2023 Date/Time Prepared: To 5/22/2024 9:54 am Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 0 HOSPICE ROUTINE HOME CARE 0 779, 028 0 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 0 0 12, 799 52.00 0 52.00 0 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 n 60.00 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 0 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00

0 0

0

0

0

6.865

0

798, 692 100. 00

0

71.00

99.00

71 00

100.00 TOTAL

OTHER NONREIMBURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER

Health Financial Systems	PANA COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICI	E GENERAL SERVICE COSTS	Provider CCN:	14-1341	Peri od: From 01/01/2023	Worksheet 0-6 Part II
STATISTIONE BASIS		Hospi ce CCN:	14-1575	To 12/31/2023	Date/Time Prepared:

			Hospi ce cci	: 14-15/5 10	0 12/31/2023	5/22/2024 9:5	
					Hospi ce I	072272021 7.0	ı uıı
	Cost Center Descriptions	CAP REL BLDG & CA	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	, , , , , , , , , , , , , , , , , , ,	FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)		,	
		1.00	2. 00	3. 00	4A	4. 00	
_	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
1.00	CAP REL COSTS-BLDG & FLXT	0					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		6, 846				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	o	o	345, 817			3. 00
4.00	ADMINISTRATIVE & GENERAL	0	6, 846	82, 354	-362, 616	436, 076	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	0	0	0	0	4, 442	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	Ō	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9. 00	NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES		0	0	0	273	10.00
11. 00	MEDICAL RECORDS		0	0	0	4, 079	11. 00
12. 00	STAFF TRANSPORTATION		0	0	0	4, 077	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION		0	0	0	0	13. 00
14. 00	PHARMACY		0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICES	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	U	0	0	17. 00
17.00	LEVEL OF CARE	U	Ų		U	U	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50. 00
51. 00	HOSPICE CONTINUOUS HOME CARE			263, 463	0	420, 996	51.00
52.00	HOSPICE ROUTINE HOME CARE	0	o	203, 403	-		52.00
			0	0	0	2, 538	
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	U U	υĮ	U	U	0	53. 00
60. 00	BEREAVEMENT PROGRAM	0	O	0	0	0	60. 00
61. 00	VOLUNTEER PROGRAM		0	0	0	0	61.00
62. 00	FUNDRAL SI NG		0	0	0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM		0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES		0	0	0	0	65. 00
66. 00	1		0	0	0	0	66. 00
	RESI DENTI AL CARE		0	0	0	0	
67. 00	ADVERTI SI NG	0	0	0	U	ū	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
69. 00		U	٥	U	0	Ü	69. 00
70.00	NURSING FACILITY ROOM & BOARD			_	0	0.740	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	٩	Ü	U	3, 748	
99. 00	NEGATI VE COST CENTER		, , , , , ,	100.050		2/2 /4/	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		6, 990	100, 950		362, 616	
101.00	UNIT COST MULTIPLIER	0. 000000	1. 021034	0. 291917		0. 831543	101.00

Health Financial Systems	PANA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der CO	CN: 14-1341	Peri od:	Worksheet 0-6	
STATISTICAL BASIS				From 01/01/2023		
		Hospi ce CCN	N: 14-1575	To 12/31/2023		
					5/22/2024 9:5	<u>4 am </u>
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	NURSI NG	

			Hospi ce CCI	N: 14-1575 T	o 12/31/2023	Date/Time Pre 5/22/2024 9:5	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	,	DAYS)		
		(SQUARE FEET)	DAYS)		,	(DIRECT NURS.	
		,				HRS.)	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE	5, 933					5. 00
6.00	LAUNDRY & LINEN SERVICE	0,700	0				6.00
7. 00	HOUSEKEEPI NG	0	٥	1			7. 00
8. 00	DI ETARY	0			_		8.00
		0			U		
9.00	NURSI NG ADMI NI STRATI ON	0				0	
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	
11. 00	MEDI CAL RECORDS	0		0		0	
12. 00	STAFF TRANSPORTATION	0		0		0	
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13. 00
14.00	PHARMACY	0		0		0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16.00	OTHER GENERAL SERVICE	0		0		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE		•				
50.00	HOSPI CE CONTI NUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	5, 933	0	0	0		
53. 00	HOSPICE GENERAL INPATIENT CARE	0,700	0		0		
55. 00	NONREI MBURSABLE COST CENTERS			1			33.00
60.00	BEREAVEMENT PROGRAM	0				0	60.00
61. 00	VOLUNTEER PROGRAM	0		1 0		0	
62. 00	FUNDRAI SI NG	0				0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	
		0				0	
64. 00	PALLIATIVE CARE PROGRAM	0					
65. 00	OTHER PHYSI CI AN SERVI CES	0		0		0	
66. 00	RESI DENTI AL CARE	0	0	0	0	0	
67. 00	ADVERTI SI NG	0		0		0	
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	
69. 00	THRI FT STORE	0		0		0	1 0 / 1 0 0
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATI VE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	8, 136	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1. 371313	0. 000000	0.000000	0. 000000	0.000000	101. 00

Health Financial Systems	PANA COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE COSTS	Provider CCN: 14-1341		Worksheet 0-6
STATISTICAL BASIS			From 01/01/2023	Part II

STATES	TATISTICAL BASIS				o 12/31/2023	Date/Time Pre 5/22/2024 9:5	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	·	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES	4, 702					10. 00
11. 00	MEDICAL RECORDS		4, 702				11. 00
12.00	STAFF TRANSPORTATION			1 0			12. 00
13.00	VOLUNTEER SERVICE COORDINATION			1 0	ol		13. 00
14. 00	PHARMACY			1 0	ol ol	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			1	ol ol	0	1
16. 00	OTHER GENERAL SERVICE			1		0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE			•	· · · · · · · · · · · · · · · · · · ·		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		ol	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	4, 693	4, 693		ol ol	0	1
52. 00	HOSPICE INPATIENT RESPITE CARE	9	9		ol	0	52.00
	HOSPICE GENERAL INPATIENT CARE	0	0	1		0	1
	NONREI MBURSABLE COST CENTERS				<u>'</u>		1
60.00	BEREAVEMENT PROGRAM			(0	0	60.00
61. 00	VOLUNTEER PROGRAM			1 0	ol ol	0	61. 00
62.00	FUNDRAI SI NG			1 0	ol ol	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			1 0	ol ol	0	63. 00
64.00	PALLIATIVE CARE PROGRAM			1 0	ol ol	0	64.00
65.00	OTHER PHYSICIAN SERVICES			1 0	ol ol	0	65. 00
66. 00	RESI DENTI AL CARE			1 0	ol ol	0	66. 00
67.00	ADVERTI SI NG			1 0	ol ol	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			1 0	ol ol	0	68. 00
69. 00	THRI FT STORE				ol	0	1
	NURSING FACILITY ROOM & BOARD]		70.00
	OTHER NONREIMBURSABLE (SPECIFY)			1 0	ol ol	0	
	NEGATIVE COST CENTER]		99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	500	7, 471	1 0	ol ol	0	100.00
	UNIT COST MULTIPLIER	0. 106338			0. 000000		
		1		'	1		•

Health Financial Systems	PANA COMMUNITY HO	OSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS		Provi der CCN: Hospi ce CCN:	 From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared:

						5/22/2024 9: 54	am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
				DAYS)			
		15.00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS			•	•		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDICAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00							
	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16. 00	OTHER GENERAL SERVICE		0				16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				וע		17. 00
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE	0	0	1			50.00
	HOSPICE ROUTINE HOME CARE	0	0	1			51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0				52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	()		53. 00
	NONREI MBURSABLE COST CENTERS			T	T		
60.00	BEREAVEMENT PROGRAM		0				60.00
61. 00	VOLUNTEER PROGRAM		0)			61. 00
62. 00	FUNDRAI SI NG		0)			62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0)			63. 00
64. 00	PALLIATIVE CARE PROGRAM		0)			64. 00
65.00	OTHER PHYSICIAN SERVICES		0	1			65.00
66.00	RESI DENTI AL CARE	0	0	(66.00
67.00	ADVERTI SI NG		0)			67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0)			68.00
69.00	THRI FT STORE		0)			69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	(71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part	1)	0	(1	100. 00
101.00	UNIT COST MULTIPLIER "	0. 000000	0. 000000	0. 000000		1	101. 00
	ı		1	•		'	

	Financial Systems	PANA COMMUNIT				u of Form CMS-	
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SE OF CARE	RVICE COSIS BY	Provi der CO	CN: 14-1341	Peri od: From 01/01/2023	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	l: 14-1575	To 12/31/2023	Date/Time Pre 5/22/2024 9:5	pared: 4 am
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to Chargo	HCHC	HRHC	HI RC	
	cost center bescriptions	Part I, Col. 9		пспс	пкпс	ni kc	
		line	Ratio				
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	0. 460198		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67. 00					2.00
3.00	SPEECH PATHOLOGY	68. 00					3.00
4. 00	DRUGS CHARGED TO PATIENTS	73. 00	0. 301007		0 0	0	
5. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6. 00	LABORATORY	60. 00	0. 173627		0 0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 136902		0 0	0	/ /
8. 00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76. 00					10.00
11.00	Totals (sum of lines 1-11)	Charges by LOC		Charad Carri	ice Costs by LOC		11. 00
		(from Provider		Silai eu Sei vi	ICE COSTS BY LOC		
		Records)					
	Cost Center Descriptions		HCHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGIP (col. 1 x	
	•		col . 2)	col. 3)	col. 4)	col. 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2. 00	OCCUPATI ONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5. 00 6. 00	DURABLE MEDICAL EQUIP-RENTED LABORATORY		0		0	0	5. 00 6. 00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT		0			0	
7. 00 8. 00	OTHER OUTPATIENT SERVICE COST CENTER	١	U				8.00
9. 00	RADI OLOGY-THERAPEUTI C						9.00
	OTHER ANCILLARY SERVICE COST CENTERS						10.00

10.00 0 11.00

10.00 OTHER ANCILLARY SERVICE COST CENTERS
11.00 Totals (sum of lines 1-11)

		nospi ce con	1. 11 1070	0 12/01/2020	5/22/2024 9: 54	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)		0	0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			779, 028	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 693	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				166. 00	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	4, 440			9. 00
10.00	Program cost (line 8 times line 9)		737, 040	16, 932		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00		7, col. 8,			12, 799	11. 00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				9	12.00
	Total average cost per diem (line 11 divided by line 12)				1, 422. 11	
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	9	0		14.00
15. 00	Program cost (line 13 times line 14)		12, 799	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			0	16. 00
	line 11)				_	
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17. 00
	Total average cost per diem (line 16 divided by line 17)	>	_	_	0.00	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	0	0		19. 00
20. 00	Program cost (line 18 times line 19)		0	0		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				791, 827	21. 00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				4, 702	
23. 00	Average cost per diem (line 21 divided by line 22)				168. 40	23. 00

Heal th	Financial Systems	PANA COMMUNI	TY HOSPITAL		In Li€	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023		narod:
			Component	CCN. 14-0500	10 12/31/2023	5/22/2024 9: 5	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physi ci an	735, 798	0	735, 79	-26, 553	709, 245	1.00
2.00	Physician Assistant	0	Ö) , , , ,	0 20,000	0	2.00
3.00	Nurse Practitioner	603, 575	O	603, 57	5 -3, 966	599, 609	
4.00	Visiting Nurse	0	o		0 0	0	4. 00
5.00	Other Nurse	425, 382	0	425, 38	-2, 261	423, 121	5. 00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	25, 359	25, 35	9 0	25, 359	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	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)	1, 764, 755					
11.00	Physician Services Under Agreement	07.407	207, 815				
12.00	Physician Supervision Under Agreement	27, 697	0	27, 69		27, 697	12. 00 13. 00
13. 00 14. 00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	27, 697	207, 820	235, 51	7 57, 560	5 293, 077	14.00
15. 00	Medical Supplies	27,097	178, 587			178, 587	
16. 00	Transportation (Health Care Staff)		170,567	170,50		170,507	16.00
	Depreciation-Medical Equipment				0 0		
18. 00	Professional Liability Insurance		29, 187	29, 18	7	29, 187	
19. 00	Other Health Care Costs	0	1, 118			1, 118	1
		1	., 110	1 '' ''	-1	1 .,	1

1, 792, 452

329, 328

329, 328

2, 121, 780

208, 892

442, 071

0

3, 113

3, 113

4, 687

224, 428

229, 115

674, 299

208, 892

0

0

0

3, 113

3, 113

4, 687

553, 756

558, 443

2, 796, 079

2, 234, 523

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28. 00

29.00

30.00

31.00

32.00

0

0

32, 780

-54, 447

-21, 667

2, 212

556, 022

558, 234

2, 795, 870

208, 892

2, 259, 303

24, 780

32, 780

-57, 560

-24, 780

-2, 475

2, 266

-209

-209

o

0

20.00

21. 00

22.00

23.00

24.00

25.00

25. 01

25.02

26.00

27.00

28. 00

31.00

32.00

Allowable GME Costs

lines 10, 14, and 21)

Chronic Care Management

Nonallowable GME costs

Pharmacy

Optometry

Tel eheal th

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

Dental

Subtotal (sum of lines 15 through 20)

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1341	Peri od: Worksheet M-1 From 01/01/2023			
	Component CCN: 14-8508	To 12/31/2023 Date/Time Prepared:			

			Component	CCN. 14-0500	10	12/31/2023	5/22/2024 9:	
						RHC I	Cost	
		Adjustments	Net Expenses					
			for Allocation	n				
			(col. 5 + col.					
			6)					
		6. 00	7. 00	1				
	FACILITY HEALTH CARE STAFF COSTS			•				
1.00	Physi ci an	-25, 695	683, 550					1.00
2.00	Physician Assistant	0	C	ol				2. 00
3.00	Nurse Practitioner	0	599, 609					3. 00
4.00	Visiting Nurse	0		ol				4. 00
5.00	Other Nurse	0	423, 121					5.00
6.00	Clinical Psychologist	0	(6. 00
7. 00	Clinical Social Worker	0	25, 359					7. 00
7. 10	Marriage and Family Therapist	_						7. 10
7. 11	Mental Health Counselor							7. 11
8. 00	Laboratory Techni ci an	0						8. 00
9. 00	Other Facility Health Care Staff Costs		_	1				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	-25, 695	_					10.00
11. 00	Physician Services Under Agreement	20,070		•				11. 00
12. 00	Physician Supervision Under Agreement			•				12. 00
13. 00	Other Costs Under Agreement			•				13. 00
14. 00	Subtotal (sum of lines 11 through 13)		_	1				14. 00
15. 00	Medical Supplies		178, 587	1				15. 00
16. 00	Transportation (Health Care Staff)		170,007	1				16. 00
17. 00	Depreciation-Medical Equipment							17. 00
18. 00	Professional Liability Insurance		29, 187	7				18. 00
	Other Health Care Costs		1, 118	•				19. 00
20. 00	Allowable GME Costs		1, 110	1				20.00
21. 00	Subtotal (sum of lines 15 through 20)		208, 892					21. 00
22. 00	Total Cost of Health Care Services (sum of	-25, 695						22. 00
22.00	lines 10, 14, and 21)	25, 075	2, 233, 000	1				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1				
23. 00	Pharmacy	0	(23. 00
24. 00	Dental			1				24. 00
25. 00	Optometry	0						25. 00
	Tel eheal th	0	32, 780					25. 01
	Chronic Care Management	0						25. 02
	All other nonreimbursable costs		_	7				26. 00
27. 00	Nonallowable GME costs		0 .,					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	-21, 667	7				28. 00
20.00	through 27)		21,007					20.00
	FACILITY OVERHEAD		l .	1				
29. 00	Facility Costs	0	2, 212					29.00
30.00	Admi ni strati ve Costs			1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and			1				31. 00
550	30)		333, 20					000
32. 00	Total facility costs (sum of lines 22, 28	-25, 695	2, 770, 175	5				32. 00
	and 31)							
	•	'	•	•				

Health Financial Systems PANA COMMUNITY HOSPITAL					In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provi der C		Peri od:	Worksheet M-1		
			Component		From 01/01/2023 To 12/31/2023			
					RHC II	Cost		
		Compensation	Other Costs		1 Reclassi ficati			
				+ col . 2)	ons	Trial Balance		
						(col. 3 + col. 4)		
		1.00	2.00	3.00	4. 00	5. 00		
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	326, 947	0	326, 94	-7, 215	319, 732	1. 00	
2.00	Physician Assistant	0	0)	0	0	2. 00	
3.00	Nurse Practitioner	177, 771	0	177, 77	-7, 042	170, 729	3. 00	
4.00	Visiting Nurse	0	0)	0	0	4. 00	
5 00	Other Nurse	276 960		276 06	vol o	276 060	5 00	

		oompensati on	011101 00313	+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4.00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3. 00	4. 00	5.00	
1. 00	Physi ci an	326, 947	0	326, 947	-7, 215	319, 732	1. 00
2.00	Physician Assistant	020,717	Ö	020, 717	7,210	017,732	2. 00
3. 00	Nurse Practitioner	177, 771	0	177, 771	-7, 042	170, 729	3. 00
4.00	Visiting Nurse	. 0	0	. 0	0	0	4. 00
5.00	Other Nurse	276, 960	O	276, 960	0	276, 960	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	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)	781, 678	0	781, 678	-14, 257		
11. 00	Physician Services Under Agreement	0	265, 614	265, 614	0	265, 614	11. 00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13. 00 14. 00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	265, 614	265, 614	0	0 265, 614	13. 00 14. 00
15. 00	Medical Supplies	0	88, 027	88, 027	0	88, 027	15. 00
	Transportation (Health Care Staff)	0	00, 027	00, 027	0	08,027	16. 00
17. 00	Depreciation-Medical Equipment	0	0	0	0		17. 00
	Professional Liability Insurance	0	19, 665	19, 665	0	19, 665	
19. 00	Other Health Care Costs	0	0	. , , 555	0	0	19. 00
	Allowable GME Costs	J	, and the second second second second second second second second second second second second second second se	Ü	· ·		20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	107, 692	107, 692	0	107, 692	21. 00
22. 00	Total Cost of Health Care Services (sum of	781, 678	373, 306	1, 154, 984	-14, 257		22. 00
	lines 10, 14, and 21)		·				
	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	Tel eheal th	0	0	0	14, 257	14, 257	
25. 02 26. 00	Chronic Care Management All other nonreimbursable costs	0	0	0	0	0	25. 02 26. 00
26.00	Nonallowable GME costs	0	U	U	U	U	26.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	_	0	0	14, 257	14, 257	28. 00
20.00	through 27)	0	O	O	14, 237	14, 237	20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	14, 446	14, 446	0	14, 446	29. 00
30.00	Administrative Costs	240, 596	112, 108	352, 704	0	352, 704	30.00
31.00	Total Facility Overhead (sum of lines 29 and	240, 596	126, 554	367, 150	0	367, 150	31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	1, 022, 274	499, 860	1, 522, 134	0	1, 522, 134	32. 00
	and 31)						

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS	Provider CCN: 14-1341	Peri od: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8633	To 12/31/2023 Date/Time Prepared:

			Comporte	iii con	v. 14-0033	10	12/31/2023	5/22/2024 9:	
							RHC II	Cost	
		Adjustments	Net Expens	ses					
		•	for Alloca	ti on					
			(col. 5 + 0)	col.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	319	732					1. 00
2.00	Physician Assistant	0		0					2. 00
3.00	Nurse Practitioner	0	170	729					3. 00
4.00	Visiting Nurse	0		O					4. 00
5.00	Other Nurse	0	276	960					5. 00
6.00	Clinical Psychologist	0		o					6. 00
7.00	Clinical Social Worker	0		o					7. 00
7. 10	Marriage and Family Therapist								7. 10
7. 11	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0		o					8. 00
9.00	Other Facility Health Care Staff Costs	0		o					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	767	421					10.00
11. 00	Physician Services Under Agreement	0		614					11. 00
12. 00	Physician Supervision Under Agreement	0		o					12. 00
13. 00	Other Costs Under Agreement	0		o					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	265	614					14. 00
15. 00	Medical Supplies	0		027					15. 00
16. 00	Transportation (Health Care Staff)	0		0					16. 00
17. 00	Depreciation-Medical Equipment	0		o					17. 00
18. 00	Professional Liability Insurance	0	19	665					18. 00
19. 00	Other Health Care Costs	0		0					19. 00
20. 00	Allowable GME Costs	ŭ							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	107	692					21. 00
22. 00	Total Cost of Health Care Services (sum of	0							22. 00
22.00	lines 10, 14, and 21)	Ü	1, 110	, _ ,					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		L						
23. 00	Pharmacy	0		0					23. 00
24. 00	Dental	0		ol					24. 00
25.00	Optometry	0		ol					25. 00
25. 01	Tel eheal th	0	14.	257					25. 01
25. 02	Chronic Care Management	0		o					25. 02
26. 00	All other nonreimbursable costs	0		o					26. 00
27. 00	Nonallowable GME costs	_							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	14	257					28. 00
20.00	through 27)	ŭ		207					20.00
	FACILITY OVERHEAD								
29. 00		0	14.	446					29. 00
30. 00	Administrative Costs	0		704					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0		150					31. 00
	30)	· ·							
32.00	Total facility costs (sum of lines 22, 28	0	1, 522	134					32. 00
	and 31)								
									-

Heal th	Financial Systems	PANA COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 14-1341	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 14-8637		Date/Time Prep 5/22/2024 9:54	oared: 4 am
					RHC III	Cost	
	<u> </u>	Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
				·		(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	4, 352	0	4, 35	52 0	4, 352	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
2 00	N D	200 750		200 7	-0 -0 -7	150 100	2 00

		Compensation	Other Costs		Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4.00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3. 00	4. 00	5.00	
1. 00	Physician	4, 352	0	4, 352		4, 352	1. 00
2. 00	Physician Assistant	4, 332	0	4, 332	0	4, 352	2. 00
3. 00	Nurse Practitioner	208, 759	0	208, 759	-58, 567	150, 192	3. 00
4. 00	Visiting Nurse	200, 739	0	200, 739	-30, 307	150, 192	4. 00
5. 00	Other Nurse	80, 322	0	80, 322	0	80, 322	5. 00
6. 00	Clinical Psychologist	00, 322	0	00, 322	0	00, 322	6. 00
7. 00	Clinical Social Worker	0	0		0	0	7. 00
7. 10	Marriage and Family Therapist	U	U	1	0	0	7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Technician	_	0		0	0	8. 00
9. 00		0	0		0	0	9. 00
10. 0		293, 433	0	293, 433	-58, 567	234, 866	10. 00
11. 0		293, 433	0	293, 433	-30, 307	234, 000	11. 00
12. 0		0	0		0	0	12.00
13. 0		0	0		0	0	13. 00
14. 0	<u> </u>	0	0		0	0	14. 00
15. 0	,	0	9, 294	9, 294	0	9, 294	15. 00
16. 0		0	7, 274	7, 274	0	7, 274	16. 00
17. 0		0	0		0	0	17. 00
18. 0		0	0		0	0	18. 00
19. 0	,	0	3, 103	3, 103	0	3, 103	
20. 0		U	3, 103	3, 103	0	3, 103	20. 00
21. 0		0	12, 397	12, 397	0	12, 397	21. 00
22. 0	`	293, 433	12, 397				22. 00
22.0	lines 10, 14, and 21)	273, 433	12, 377	303, 630	-36, 367	247, 203	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			l		l	
23. 0		0	0	0	0	0	23. 00
24. 0		0	0	0	0	0	24. 00
25. 0		0	0	o o	0	0	25. 00
25. 0	'	0	0	o o	58, 567	58, 567	25. 01
25. 0		0	0	0	0	0	25. 02
26. 0	9	0	0	0	0	0	26. 00
27. 0			_	_	_		27. 00
28. 0		0	0	0	58, 567	58, 567	28. 00
20.0	through 27)	, and the second			00,007	00,007	20.00
	FACILITY OVERHEAD	l		'	l		
29. 0		0	1, 897	1, 897	0	1, 897	29. 00
30.0	Administrative Costs	68, 644	39, 857	108, 501	0	108, 501	30. 00
31.0	Total Facility Overhead (sum of lines 29 and	68, 644	41, 754	1	0	110, 398	31. 00
	30)						
32.0	Total facility costs (sum of lines 22, 28	362, 077	54, 151	416, 228	0	416, 228	32.00
	and 31)						

Health Financial Systems	PANA COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-1	10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1341	Peri od: Worksheet M-1	
	Component CCN: 14-8637	From 01/01/2023 To 12/31/2023 Date/Time Prepared:	l:

			Component	CCIV:	14-8037	10	12/31/2023	5/22/2024 9:	
							RHC III	Cost	01 4
		Adjustments	Net Expenses						
			for Allocation						
			(col. 5 + col.	.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	4, 35						1. 00
2.00	Physi ci an Assi stant	0		0					2. 00
3.00	Nurse Practitioner	0	150, 19	2					3. 00
4.00	Visiting Nurse	0		0					4. 00
5. 00	Other Nurse	0	80, 32	1					5. 00
6.00	Clinical Psychologist	0		0					6. 00
7.00	Clinical Social Worker	0	'	U					7. 00
7. 10	Marriage and Family Therapist								7. 10
7. 11	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0		0					8. 00
9.00	Other Facility Health Care Staff Costs	0		0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	234, 86	1					10. 00 11. 00
11.00	Physician Services Under Agreement	0		0 0					12.00
12. 00 13. 00	Physician Supervision Under Agreement	0		0					13. 00
14. 00	Other Costs Under Agreement	0		0					14. 00
15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	9, 29	-1					15. 00
16. 00	Transportation (Health Care Staff)	0		0					16. 00
17. 00	Depreciation-Medical Equipment	0							17. 00
18. 00	Professional Liability Insurance	0		n					18. 00
19. 00	Other Health Care Costs	0	3, 10	3					19. 00
20. 00	Allowable GME Costs	0	3, 10	٦					20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	12, 39	7					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	247, 26						22. 00
22.00	lines 10, 14, and 21)	J	217,20						22.00
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	(0					23. 00
24.00	Dental	0	(ol					24. 00
25.00	Optometry	0	(0					25. 00
25. 01	Tel eheal th	0	58, 56	7					25. 01
25. 02	Chronic Care Management	0	(0					25. 02
26. 00	All other nonreimbursable costs	0	(0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	58, 56	7					28. 00
	through 27)								
	FACILITY OVERHEAD								
	Facility Costs	0	.,						29. 00
30. 00	Administrative Costs	0	108, 50						30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	110, 39	8					31. 00
22.00	30)	-	417.00						22.00
32. 00	Total facility costs (sum of lines 22, 28	O	416, 22	g					32. 00
	and 31)		I	I					1

	Financial Systems	PANA COMMUNI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provider CO		Period: From 01/01/2023	Worksheet M-2	
			Component (To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	2. 01	6, 983	4, 20	0 8, 442		1.00
2.00	Physi ci an Assi stant	0.00		-,			2. 00
3.00	Nurse Practitioner	3. 65		2, 10			3. 00
4.00	Subtotal (sum of lines 1 through 3)	5. 66			16, 107		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. 10				217	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7.02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
7. 03	only) Marriage and Family Therapist						7. 03
7.03	Mental Health Counselor						7.03
8.00	Total FTEs and Visits (sum of lines 4	5. 76	16, 051			16, 324	8.00
0.00	through 7)	3.70	10,031			10, 324	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPITAL-BASE	D RHC/FOHC SER	VICES		1. 00	
10.00						2, 233, 608	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					-21, 667	1
12.00	Cost of all services (excluding overhead) (s					2, 211, 941	12.00
13.00	Ratio of hospital -based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 009795	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		558, 234	14. 00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	tions)			1, 457, 262	
16. 00						2, 015, 496	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					2, 015, 496	
	Overhead applicable to hospital-based RHC/FQ					2, 035, 238	1
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (s	um of lines 10	and 19)		4, 268, 846	20.00

	Financial Systems	PANA COMMUNI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od: From 01/01/2023	Worksheet M-2	
			Component	CCN: 14-8633	To 12/31/2023	5/22/2024 9:5	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel			(col. 1 x col. 3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 31			•		1.00
2.00	Physician Assistant	0. 00		_,			2. 00
3.00	Nurse Practitioner	1. 24	,		•		3. 00
4.00	Subtotal (sum of lines 1 through 3)	2. 55			8, 106		4.00
5.00	Visiting Nurse	0.00	1			0	5.00
6.00	Clinical Psychologist	0.00	1			0	6.00
7.00	Clinical Social Worker	0.00	1			0	7.00
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00				0	7. 01 7. 02
7.02	only)	0.00) U			U	7.02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	2. 55	6, 957			8, 106	8.00
0.00	through 7)	2.00	0,707			0, 100	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
	•						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
10.00	Total costs of health care services (from Wk					1, 140, 727	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					14, 257	
12.00	Cost of all services (excluding overhead) (s					1, 154, 984	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 987656	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		367, 150	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			734, 871	
16.00						1, 102, 021	16.00
17. 00	Allowable GME overhead (see instructions)					1 102 021	17. 00
18.00	Enter the amount from line 16	IIC comilece (I:	no 10 v lin- 1	0)		1, 102, 021	
	Overhead applicable to hospital based RHC/FQ			*		1, 088, 418	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	sum of fines to	and 19)		2, 229, 145	₁ 20.00

	Financial Systems	PANA COMMUNI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od: From 01/01/2023	Worksheet M-2	
			Component	CCN: 14-8637	To 12/31/2023	5/22/2024 9:5	
					RHC III	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel			(col. 1 x col. 3)	4	
		1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 04	1				1. 00
2.00	Physician Assistant	0. 00	1	_,			2. 00
3.00	Nurse Practitioner	1. 08			•		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 12		1	2, 436		4. 00
5.00	Visiting Nurse	0.00	1	•		0	5. 00
6.00	Clinical Psychologist	0.00	1			0	6.00
7.00	Clinical Social Worker	0.00	1			0	7.00
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01 7. 02
7.02	Diabetes Self Management Training (FQHC only)	0. 00) 			U	7.02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4	1. 12	3, 459			3, 459	8.00
0.00	through 7)					0, 10,	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
10.00	Total costs of health care services (from Wk					247, 263	
11.00	Total nonreimbursable costs (from Wkst. M-1,					58, 567	
12.00	Cost of all services (excluding overhead) (s					305, 830	
13.00	Ratio of hospital based RHC/FQHC services (I			no 21)		0. 808498	
14. 00 15. 00	Total hospital-based RHC/FQHC overhead - (from Parent provider overhead allocated to facili			ne 31)		110, 398 258, 674	
16. 00		ty (see instruc	LI 0115)			369, 072	16.00
17. 00	Allowable GME overhead (see instructions)					369, 072	17. 00
18. 00	Enter the amount from line 16					369, 072	
	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		298, 394	
	Total allowable cost of hospital based RHC/F					545, 657	
_0.00	1. Sta. a Shabi o cost of hospital based known	a 301 V1 003 (3	Ja 01 111103 10	a 17)		0.10, 007	0.00

CALCUL	Financial Systems PANA COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1341	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C	ES	Component CCN: 14-8508	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			4, 268, 846	
2.00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 m			61, 070	
3. 00 4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	inus iine 2)		4, 207, 776 16, 324	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			16, 324	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	257.77 of limit (1)	7. 00
			Rate Period N/A	Rate Period 1	
			IN/ A	(01/01/2023 through	
				12/31/2023)	
0.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	(or vous contractor)	1.00	2. 00	0.00
8. 00 9. 00	Rate for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 0. 00	271. 90 257. 77	
	CALCULATION OF SETTLEMENT				1
10.00	Program covered visits excluding mental health services (from	*	0	2, 750	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra	•	0	708, 868 9	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x lines)		0	2, 320	
14. 00	Limit adjustment for mental health services (see instructions	•	0	2, 320	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction: Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	711, 188	15. 00 16. 00
16. 00	Total program charges (see instructions) (from contractor's re		0	638, 853	
16. 02	Total program preventive charges (see instructions)(from provi	*		46, 756	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		52, 050	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		473, 279	16. 04
16. 05	Total program cost (see instructions)		0	525, 329	16. 05
17.00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		67, 539	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		104, 064	19. 00
20.00	Net program cost excluding injections/infusions (see instruct	•		525, 329	
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		13, 747	21. 00 21. 50
21. 55	Total program IOP Costs (see instructions)				21. 55
21. 60	Program IOP coinsurance (see instructions)				21. 60
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		539, 076	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			8, 887 5, 777	
24. 00	1 *	ructions)		8, 887	1
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction: Demonstration payment adjustment amount before sequestration	s)		0	
26. 00	Net reimbursable amount (see instructions)			544, 853	
26. 01	Sequestration adjustment (see instructions)			10, 897	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			441.064	
28. 00	Interim payments Tentative settlement (for contractor use only)			441, 064 0	1
29. 00		02, 27, and 28)		92, 892	
30.00		•		0	1

CALCULATI ON	ncial Systems PANA COMMUNITY N OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1341	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 14-8633	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/22/2024 9:54	
		Title XVIII	RHC II	Cost	
				1. 00	
	RMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
	al Allowable Cost of hospital-based RHC/FQHC Services (from			2, 229, 145	
	of injections/infusions and their administration (from Wi al allowable cost excluding injections/infusions (line 1 m			29, 100 2, 200, 045	
1	nd Visits (from Wkst. M-2, column 5, line 8)	riius i riie 2)		8, 106	•
	sicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
	al adjusted visits (line 4 plus line 5) usted cost per visit (line 3 divided by line 6)			8, 106 271. 41	
7.00 Auj u	isted cost per visit (iiile 3 divided by iiile 6)		Cal cul ati on		7.00
			Rate Period N/A	Rate Period 1 (01/01/2023	
			147 74	through	
			1.00	12/31/2023)	
8. 00 Per	visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 999. 00	8.00
9.00 Rate	e for Program covered visits (see instructions)		0.00		1
	ULATION OF SETTLEMENT			4 00/	1.0.0
	gram covered visits excluding mental health services (from gram cost excluding costs for mental health services (line	•	0	1, 836 498, 309	
, ,	gram covered visits for mental health services (from contra	•	0	0	1
1 0	gram covered cost from mental health services (line 9 x li		0	0	
1	t adjustment for mental health services (see instructions duate Medical Education Pass Through Cost (see instructions	•	0	0	14. 0
1	al Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	498, 309	
1	al program charges (see instructions)(from contractor's re	•		322, 289	•
1	al program preventive charges (see instructions)(from provial program preventive costs ((line 16.02/line 16.01) times	•		45, 361 70, 135	
4	al Program non-preventive costs ((Time 10.02/Time 10.07) times	-		321, 194	
	les V and XIX see instructions.)			224 222	
1	al program cost (see instructions) nary payer amounts		0	391, 329 107	1
1	s: Beneficiary deductible for RHC only (see instructions)	(from contractor		26, 682	
1	ords)	> (6		40 (44	10.00
	eficiary coinsurance for RHC/FQHC services (see instruction ords)	ns) (from contractor		49, 644	19.00
1	program cost excluding injections/infusions (see instruct	i ons)		391, 222	20.00
	gram cost of vaccines and their administration (from Wkst.	M-4, line 16)		13, 092	•
1	al program IOP OPPS payments (see instructions) al program IOP Costs (see instructions)				21. 50
	gram IOP coinsurance (see instructions)				21. 60
1	al reimbursable Program cost (sum of lines 20, 21, 21.50, i	minus line 21.60)		404, 314	•
	owable bad debts (see instructions) usted reimbursable bad debts (see instructions)			2, 654 1, 725	1
1 -	owable bad debts for dual eligible beneficiaries (see inst	ructions)		2, 654	
1	R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	neer ACO demonstration payment adjustment (see instruction: onstration payment adjustment amount before sequestration	S)		0	
	reimbursable amount (see instructions)			406, 039	
	uestration adjustment (see instructions)			8, 121	1
	onstration payment adjustment amount after sequestration erim payments			0 149, 127	
	erim payments eative settlement (for contractor use only)			149, 127	1
29. 00 Bal a	ance due component/program (line 26 minus lines 26.01, 26.0			248, 791	29. 0
30.00 Prot	ested amounts (nonallowable cost report items) in accordan oter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

	NA COMMUNITY			u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BA	SED RHC/FQHC	Provider CCN: 14-1341	Peri od: From 01/01/2023	Worksheet M-3	
SERVI CES		Component CCN: 14-8637	To 12/31/2023	Date/Time Pre	pared
		Titl Marie	BUO LLI	5/22/2024 9: 5	4 am
		Title XVIII	RHC III	Cost	
				1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHO					
.00 Total Allowable Cost of hospital-based RHC/FQHC:	•			545, 657	
2.00 Cost of injections/infusions and their administra 3.00 Total allowable cost excluding injections/infusion	•			2, 548 543, 109	
.00 Total Visits (from Wkst. M-2, column 5, line 8)	0.10 (1.110 1 1			3, 459	
.00 Physicians visits under agreement (from Wkst. M-	2, column 5, l	ine 9)		0	5.
7.00 Total adjusted visits (line 4 plus line 5)	()			3, 459 157. 01	6.
7.00 Adjusted cost per visit (line 3 divided by line o	0)		Cal cul ati on		7.
				Rate Period 1	
			N/A	(01/01/2023 through	
				12/31/2023)	
			1. 00	2. 00	_
Per visit payment limit (from CMS Pub. 100-04, cl Rate for Program covered visits (see instruction:	•	6 or your contractor)	0. 00 0. 00	126. 00 126. 00	
CALCULATION OF SETTLEMENT	3)		0.00	120.00	7.
0.00 Program covered visits excluding mental health so	ervices (from	contractor records)	0	416	10.
1.00 Program cost excluding costs for mental health so		•	0	52, 416	1
2.00 Program covered visits for mental health services3.00 Program covered cost from mental health services	•	*	0	0	12. 13.
4.00 Limit adjustment for mental health services (see	•	•	0	0	
5.00 Graduate Medical Education Pass Through Cost (see					15.
6.00 Total Program cost (sum of lines 11, 14, and 15,			0	52, 416	1
6.01 Total program charges (see instructions)(from col6.02 Total program preventive charges (see instruction)				55, 994 486	1
6.03 Total program preventive costs ((line 16.02/line		•		455	1
6.04 Total Program non-preventive costs ((line 16 minutes)				36, 865	1
(Titles V and XIX see instructions.)				07.000	۱.,
6.05 Total program cost (see instructions) 7.00 Primary payer amounts			0	37, 320 29	1
8.00 Less: Beneficiary deductible for RHC only (see	instructions)	(from contractor		5, 880	
records)					
9.00 Beneficiary coinsurance for RHC/FQHC services (so	ee instruction	ns) (from contractor		9, 926	19. (
records) 20.00 Net program cost excluding injections/infusions	(see instructi	ons)		37, 291	20. (
11.00 Program cost of vaccines and their administration	•	•		1, 052	
1.50 Total program IOP OPPS payments (see instructions	s)				21.
1.55 Total program IOP Costs (see instructions) 1.60 Program IOP coinsurance (see instructions)					21.
2.00 Total reimbursable Program cost (sum of lines 20,	. 21. 21.50. r	minus line 21.60)		38, 343	ı
3.00 Allowable bad debts (see instructions)				1, 042	23.
3.01 Adjusted reimbursable bad debts (see instructions				677	1
4.00 Allowable bad debts for dual eligible beneficiar 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ies (see insti	ructions)		1, 042 0	
5.50 Pioneer ACO demonstration payment adjustment (see	e instructions	s)		0	
5.99 Demonstration payment adjustment amount before se		•		0	25.
6.00 Net reimbursable amount (see instructions)				39, 020	1
26.01 Sequestration adjustment (see instructions)26.02 Demonstration payment adjustment amount after see	nuestrati on			780 0	
7.00 Interim payments	questi ati un			30, 437	
18.00 Tentative settlement (for contractor use only)				0	28.
29.00 Balance due component/program (line 26 minus line				7, 803	
30.00 Protested amounts (nonallowable cost report item:	s) in accordar	nce with CMS Pub. 15-II,		0	30.

Heal th	Financial Systems PANA COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 14-1341	Peri od:	Worksheet M-4	
		'	CCN: 14-8508	From 01/01/2023 To 12/31/2023		
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 731, 639 0. 000185				
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	320	8:	12 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	21, 285	9, 5:	37 0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	21, 605 2, 233, 608			0 2, 233, 608	0.00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	2, 035, 238 0. 009673				
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	19, 687 41, 292			0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	108 382. 33 15	72.		0 0.00 0	12. 00
13. 01	beneficiaries 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)	5, 735	8, 0	12 0	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			61, 070	
16. 00	Total Program cost of injections/infusions and their adminicolumns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				13, 747	16. 00

	Financial Systems PANA COMMUNITATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 14-1341	Peri od:	worksheet M-4	
		Component (CCN: 14-8633	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/22/2024 9:54	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	767, 421	767, 4	21 767, 421	767, 421	1.
. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000121	0. 0004	0. 000000	0. 000000	2.
. 00	Injection/infusion health care staff cost (line 1 x line 2)	93		14 0	0	3.
. 00	Injections/infusions and related medical supplies costs (from your records)	8, 547	5, 9	37 0	0	
00	Direct cost of injections/infusions (line 3 plus line 4)	8, 640	6, 2		0	5.
00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 140, 727	1, 140, 7	27 1, 140, 727	1, 140, 727	6.
00	Total overhead (from Wkst. M-2, line 19)	1, 088, 418	1, 088, 4			
00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 007574	0. 0054			
00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	8, 244 16, 884	5, 9 12, 2		_	
1. 00	costs (sum of lines 5 and 9) Total number of injections/infusions (from your records)	46	1	56 0	0	11.
2. 00	Cost per injection/infusion (line 10/line 11)	367.04	78.			
3. 00	Number of injection/infusion administered to Program beneficiaries	25		50 0	0	1
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.
1. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9, 176	3, 9	16 0	0	14.
	Tand 10.01, as appricable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	
. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		29, 100	15
. 00	Total Program cost of injections/infusions and their admini		(sum of		13, 092	16

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 14-1341	Peri od:	Worksheet M-4	
		Component (CCN: 14-8637	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/22/2024 9:5	
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	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)	234, 866				1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000027				
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6		43 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	654		52 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	660		95 0	0	5.0
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	247, 263				
7.00	Total overhead (from Wkst. M-2, line 19)	298, 394				7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002669				8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	796		97 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1, 456			0	10.00
11. 00	Total number of injections/infusions (from your records)	4		27 0	0	11.00
12. 00	Cost per injection/infusion (line 10/line 11)	364.00	40.	0.00		
13. 00	Number of injection/infusion administered to Program beneficiaries	2		8 0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	728	3:	24 0	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
				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)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

15. 00

16.00

2, 548

Health Financial Systems	PANA COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 14-1341 Component CCN: 14-8508	From 01/01/2023 To 12/31/2023	Date/Time Prepared:
				5/22/2024 9:54 am

	omponent con. 14-0300	10 12/31/2023	5/22/2024 9: 54	
		RHC I	Cost	
		Par	t B	
		mm/dd/yyyy	Amount	
		1, 00	2, 00	
O Total interim payments paid to hospital-based RHC/FQHC			427, 937	
O Interim payments payable on individual bills, either submitted of	or to be submitted to		0	1
the contractor for services rendered in the cost reporting period				
"NONE" or enter a zero				
O List separately each retroactive lump sum adjustment amount base	ed on subsequent			١ :
revision of the interim rate for the cost reporting period. Also				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				1
1		07/19/2023	13, 127	1
2			0	
3			0	
4			o	
5			o	
Provider to Program		<u> </u>		ĺ
0			0	1
1			0	
2			0	ĺ
3			0	ĺ
4			o	
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			13, 127	İ
O Total interim payments (sum of lines 1, 2, and 3.99) (transfer t	to Worksheet M-3, line		441, 064	İ
27)				
TO BE COMPLETED BY CONTRACTOR				
O List separately each tentative settlement payment after desk rev	/iew. Also show date o	f		
each payment. If none, write "NONE" or enter a zero. (1)]
Program to Provider				
1			0	
2			0	
3			0	
Provider to Program				
0			0	
1			0	
2			0	
9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	
Determined net settlement amount (balance due) based on the cost	t report. (1)			
1 SETTLEMENT TO PROVIDER			92, 892	
2 SETTLEMENT TO PROGRAM			0	
O Total Medicare program liability (see instructions)			533, 956	
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	
O Name of Contractor		1	1	

Health Financial Systems	PANA COMMUNITY HOSPIT	ıL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL	RIES	der CCN: 14-1341	Peri od: From 01/01/2023	
	Compc	1611 CCN: 14-8633	10 12/31/2023	Date/Time Prepared:

				5/22/2024 9: 54	4 am
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			95, 304	1. (
2. 00	Interim payments payable on individual bills, either submitt	ted or to be submitted to		0	2. (
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	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)				
	Program to Provider				
. 01			07/19/2023	53, 823	3.
. 02				0	3.
. 03				0	3.
. 04				0	3.
. 05				0	3.
	Provider to Program				
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		53, 823	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		149, 127	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after desk	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5.
02				0	5.
03				0	5
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			248, 791	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			397, 918	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
. 00	Name of Contractor				8.

Health Financial Systems	PANA COMMUNITY HOSPI	AL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED I SERVICES RENDERED TO PROGRAM BENEFICIAR	ES	der CCN: 14-1341	Peri od: From 01/01/2023	
	Comp	nent CCN: 14-8637	To 12/31/2023	Date/Time Prepared:

			5/22/2024 9:5	4 am
		RHC III	Cost	
		Par	rt B	
		mm/dd/yyyy	Amount	
		1. 00	2. 00	
.00 Total interim payments paid to hospital-based RHC	C/FQHC		23, 694	1.
2.00 Interim payments payable on individual bills, eit	ther submitted or to be submitted to		0	2.
the contractor for services rendered in the cost	reporting period. If none, write			
"NONE" or enter a zero	•			
.00 List separately each retroactive lump sum adjustm	ment amount based on subsequent			3.
revision of the interim rate for the cost reporti	ng period. Also show date of each			
payment. If none, write "NONE" or enter a zero. ((1)			
Program to Provider				
. 01		07/19/2023	6, 743	3.
. 02			0	3.
03			0	3.
04			0	3.
. 05			0	3.
Provider to Program				
50			0	3.
51			0	
52			0	3
53			0	3
54			0	3
99 Subtotal (sum of lines 3.01-3.49 minus sum of lin	nes 3 50-3 98)		6, 743	3
OO Total interim payments (sum of lines 1, 2, and 3.			30, 437	4.
27)	77) (transfer to morksheet m o, fine		00, 107	١
TO BE COMPLETED BY CONTRACTOR				
.00 List separately each tentative settlement payment	t after desk review. Also show date o	f		5.
each payment. If none, write "NONE" or enter a ze				"
Program to Provider	5. 5. (1)			
01			0	5.
02			0	
03			0	5.
Provider to Program				ľ
50			0	5
51			0	
52			0	5
99 Subtotal (sum of lines 5.01–5.49 minus sum of lin	nes 5 50-5 08)			5
Determined net settlement amount (balance due) ba			0	6
01 SETTLEMENT TO PROVIDER	ised on the cost report. (1)		7, 803	6
OI SETTLEMENT TO PROVIDER O2 SETTLEMENT TO PROGRAM			7, 803	
	26)		-	
00 Total Medicare program liability (see instruction	15)	Contine	38, 240	7
		Contractor	NPR Date	
	0	Number	(Mo/Day/Yr)	
OO News of Continents	U	1. 00	2. 00	_
00 Name of Contractor			1	8.