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: 14-1327 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/17/2024 Time: 11:02 am] Manually prepared cost report use only If 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 6. Date Received: 7. Contractor No. 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 7. Contractor No. 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. In the contractor's Vendor Code: 15. In the contractor's Vendor Code: 16. NPR Date: 17. Contractor's Vendor Code: 17. Contractor's Vendor Code: 18. In the contractor's Vendor Code: 19. In the code of the code 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 WABASH GENERAL HOSPITAL DISTRICT (14-1327) 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	SIGNATURE STATEMENT	
1	Kari	ssa Turner	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	Karissa Turner			2
3	Signatory Title	CEO CEO			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	823, 141	-1, 742, 670	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	171, 204	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		16, 769		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-24, 909		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		81, 142		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		53, 784		0	10.03
10.04	RURAL HEALTH CLINIC V	0		158, 335		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		46, 445		0	10. 05
200.00	TOTAL	0	994, 345	-1, 411, 104	0	0	200.00
The ab	nove amounts represent "due to" or "due from"	the annlicable	nrogram for t	ho alamont of	the above compl	lov indicated	

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 WABASH GENERAL HOSPITAL DISTRICT In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1327 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1418 COLLEGE DRIVE 1.00 PO Box: 1.00 2.00 City: MT. CARMEL State: IL Zi p Code: 62863 County: WABASH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WABASH GENERAL HOSPITAL 141327 99914 06/01/2003 Ν 0 0 3.00 DUSTRUCT Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF WABASH GENERAL HOSPITAL 99914 06/01/2003 N 147327 N 0 7.00 7 00 SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14 00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital -Based Health Clinic - RHC WABASH GENERAL RHC 148501 99914 04/13/2009 Ν 0 Ν 15.00 Hospital-Based Health Clinic - RHC WABASH PRIMARY CARE 148568 99914 08/09/2016 15.01 0 Ν 15.01 WABASH PRIMARY CARE -148579 15 02 Hospital-Based Health Clinic - RHC 99914 10/01/2017 0 N 15 02 N IIIICOLLEGE DR Hospital-Based Health Clinic - RHC 15.03 WABASH PRIMARY CARE -148599 99914 07/01/2019 0 Ν 15.03 Ν OAK STREET Hospital-Based Health Clinic - RHC VWABASH PRIMARY CARE -148601 99914 08/09/2019 N 0 N 15.04 15.04 ALBI ON Hospital-Based Health Clinic - RHC WABASH GENERAL HOSPITAL 99914 15.05 148613 07/27/2020 Ν 0 Ν 15.05 **GRAYVILLE** Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To 1.00 2.00 12/31/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 20.00 21.00 Type of Control (see instructions) 11 21.00 1.00 2.00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Ν this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial Systems WABASH GEN	ERAL HOSPIT	AL DISTRIC	т		Inlieu	of Form CMS-	2552_10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provider C		Period: From 01/ To 12/	01/2023 31/2023	Worksheet S-2 Part I Date/Time Pre 5/17/2024 11:	epared:
			1.00	2.	00	3. 00	-
22.04 Did this hospital receive a geographic reclassificat rural as a result of the revised OMB delineations for adopted by CMS in FY 2021? Enter in column 1, "Y" for for the portion of the cost reporting period prior to in column 2, "Y" for yes or "N" for no for the portic reporting period occurring on or after October 1. (so Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter it yes or "N" for no. 23.00 Which method is used to determine Medicaid days on I	or statistic or yes or "N o October on on of the c eee instruct than 499 k n column 3,	cal areas V" for no I. Enter cost tions) peds (as "Y" for		2	N		22.04
below? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying t reporting period different from the method used in t reporting period? In column 2, enter "Y" for yes or	if census on the days in the prior control of the prior control of the prior of the	days, or 3 this cost ost o.					20.00
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day		_
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		C		C		0 0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	C	0	C		0	25.00
					Rural S 00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wo cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wo	or rural. vage) status	s at the er	nd of the co	the	2 2	2.00	26. 00 27. 00
reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassiful 15.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ication in	column 2.		n	0		35.00
					ni ng: 00	Endi ng: 2. 00	
36.00 Enter applicable beginning and ending dates of SCH s		script line	e 36 for num		50	2.00	36.00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of perio	ods MDH stat	us	0		37.00
37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)							37. 01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.							38. 00
					/N 00	Y/N 2. 00	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Er e requireme	nter in colu ents in	ume mn	N	N N	39.00

40.00

40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1327 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11: 02 am 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47 00 N N N 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or 'N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 Worksheet A NAHE 413, 85 Pass-Through Qual i fi cati on Y/N Line # Cri teri on Code 2. 00 1.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60 00 N any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IME Direct GME Direct GME IMF 1. 00 2.00 3. 00 5.00 4.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1327 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am Unwei ghted Program Name Unwei ghted Program Code IME FTE Count Direct GME FTE Count 2.00 3. 00 1.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 'Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs FTEs in Nonprovi der Hospi tal Si te 1. 00 2. 00 3. 00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.000000 64.00 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0 00 0 00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs 3/ (col. 3 + FTEs in Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 0.00 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)

1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.

HOSPI T	Financial Systems WABASH GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
				Approved for Permanent	5/17/2024 11: Number of Approved	02 am
				Adjustment (Y/N)	Permanent Adjustments	
				1. 00	2.00	
	Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			e N	0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1. 00	2. 00	3. 00	
9. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line on which the per discharge permanent adjustment approval was ba Column 2: Enter the effective date (i.e., the cost reporting pe beginning date) for the permanent adjustment to the TEFRA targe per discharge. Column 3: Enter the amount of the approved permanent adjustment	sed. riod t amount	O. C	0	0	89.00
	TEFRA target amount per discharge.			V	XIX	
				1.00	2. 00	
0. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	ervi ces? E	nter "Y" for	N	Y	90.00
	Is this hospital reimbursed for title V and/or XIX through the			N	N	91.00
2. 00	full or in part? Enter "Y" for yes or "N" for no in the applica Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certi fi cat			N	92.00
	Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.			N	N	93.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column. If line 94 is "Y", enter the reduction percentage in the applic			0. 00	0. 00	94.00
6. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.	"N" for n	o in the	N N	N N	96.00
	If line 96 is "Y", enter the reduction percentage in the applic Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	ns and res	idents post	0. 00 Y	0.00 Y	97. 00 98. 00
8. 01	Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Y	98. 01
8. 02	Does title V or XIX follow Medicare (title XVIII) for the calcu bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or " for title V. and in column 2 for title XIX.			Y	Y	98. 02
8. 03	Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes o for title V, and in column 2 for title XIX.				N	98. 03
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.			N	N	98. 04
	Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.				Y	98. 05
8. 06	Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.			Y	Y	98. 06
	Rural Providers			Y		105.00
25. nn	Does this hospital qualify as a CAH?			I I		HUD. I

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 eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42

CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

106.00

107. 00

Ν

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?

107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an

for outpatient services? (see instructions)

professional services expenses, for services purchased from unrelated organizations

located in a CBSA outside of the main hospital CBSA? In column 2, enter

Health Financial Systems	WABASH GENERAL	HOSPITAL DISTRICT	Г			In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	N: 14-1327		i od:	24 (2000	Worksheet S-2	
				To		01/2023 31/2023		pared:
							5/17/2024 11:	02 am
				-	1.	00	2. 00	-
128.00 If this is a Medicare-certified I			fication d	late				128. 00
in column 1 and termination date, 129.00 If this is a Medicare-certified I	іт арріїсаріе, іп соги ung transplant program,	ımn 2. enter the certifi	ication da	ate				129. 00
in column 1 and termination date, 130.00 If this is a Medicare-certified pa	if applicable, in colu ancreas transplant prog	ımn 2. ıram, enter the cei						130. 00
date in column 1 and termination of 131.00 If this is a Medicare-certified in	ntestinal transplant pr	ogram, enter the o	certi fi cat	i on				131. 00
date in column 1 and termination of 132.00 If this is a Medicare-certified is in column 1 and termination date,	slet transplant program	n, enter the certi	fication d	late				132. 00
133. 00 Removed and reserved	тт арритсавте, ти сого	IIIII Z.						133. 00
134.00 f this is a hospital-based organ in column 1 and termination date,			he OPO num	nber				134. 00
All Providers 140.00 Are there any related organization	n or home office costs	as defined in CMS	Pub. 15-1			V		140. 00
chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	"N" for no in column 1.	If yes, and home	office co			•		. 10. 00
1.00		2.00				3. 00		
If this facility is part of a cha office and enter the home office			ugh 143 th	ne name	e and	address	of the home	
141. 00 Name:	Contractor's Name		Contra	actor's	s Numb	er:		141. 00
142.00 Street: 143.00 Ci ty:	PO Box: State:		Zip Co	ndo.				142. 00 143. 00
143. 00 of ty.	State.		ZIP CC	Jue.				143.00
144.00	ala Paril Ial Parilla Iala						1. 00	111 00
144.00 Are provider based physicians' cos	sts included in worksne	eet A?					Y	144. 00
					1.	00	2. 00	
145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no clude Medicare utilizat	in column 1. If o	column 1 i					145. 00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the pre n column 1. (See CMS Pu			lf	1	N		146. 00
							1. 00	-
147.00 Was there a change in the statistic							N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				for no			N N	148. 00 149. 00
147. 00 was there a change to the shipiri	red cost finding method	Part A	Part E			le V	Title XIX	149.00
		1.00	2. 00			00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or	•							
155.00 Hospi tal		N	N			N	N	155. 00
156. 00 Subprovi der - IPF 157. 00 Subprovi der - IRF		N N	N N			N N	N N	156. 00 157. 00
158. OO SUBPROVI DER		IV IV	IN		,	N .	14	158. 00
159. 00 SNF		N	N			N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N			N N	N N	160. 00 161. 00
						·•		
Mul ti campus							1. 00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in di	fferen	nt CBS	As?	N	165. 00
	Name	County		Zip Co		CBSA	FTE/Campus	
166.00 If line 165 is yes, for each	0	1. 00	2.00	3. 00)	4. 00	5. 00	166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							0.00	100.00
CBSA in column 4, FTE/Campus in column 5 (see instructions)								

Health Financial Systems WABASH GENERAL HOSP	TAL DISTRICT	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 14-1327	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Pro	
			5/17/2024 11:	
			1. 00	
Health Information Technology (HIT) incentive in the American	n Recovery and Reinvestme	nt Act		
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y"	' for yes or "N" for no.		Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaning	ful user (line 167 is "Y"), enter the		168. 00
reasonable cost incurred for the HIT assets (see instructions	,			
168.01 If this provider is a CAH and is not a meaningful user, does				168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" f				
169.00 If this provider is a meaningful user (line 167 is "Y") and i	s not a CAH (line 105 is	"N"), enter the	0. 0	0169. 00
transition factor. (see instructions)				
		Begi nni ng	Endi ng	
		1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending da	ate for the reporting			170. 00
period respectively (mm/dd/yyyy)				
		1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for indi		N	(171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I				
"Y" for yes and "N" for no in column 1. If column 1 is yes, e	enter the number of secti	on		
1876 Medicare days in column 2. (see instructions)				

15.00	Did total beds available change from the prior cost report	ng period? If	yes, see instr	ructions.	N	15. 00
		Par	t A	Par	t B	
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data					
16.00		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		Υ	04/03/2024	Υ	04/03/2024	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)					
18. 00		N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	, , , , , , , , , , , , , , , , , , ,	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

## HOSPITAL MAD HOSPITAL HEALTH CARE RELIBBURSHENT OURSTLONAIRE Provider COL: 14-1327 Period: provider 101/01/2023 Part III provider 1-2 part III pr	Heal th	Financial Systems WABASH GENERAL HO	OSPLTAL DESTREC	T.	In Lie	u of Form CM	S-2552-10
Description				CN: 14-1327 F	Peri od:	Worksheet S	
Description Y/N Y/N							renared.
1.00 1.00 3.00 2.00 2.00 2.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 3.00 2.00 3.00					12/31/2023		
Report data for Other? Describe the other adjustments: Y/N Date Y/R Date							
Report data for Other? Describe the other adjustments: Y/N Date Y/N Date	2000	If line 16 or 17 is was were adjustments made to PS&P		Ü			20.00
21.00 Was the cost report prepared only using the provider's N N N 20 0 3.00 4.00 21.00 records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	20.00				14	14	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 records? If yes, see instructions. COMPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00							
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capi	21 00	Was the past report propored only using the provider's		2.00		4. 00	21.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions back changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Copy. 28.00 Were set Expense. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Have changes or new agreements occurred in patient care services furnished through contractual N 22.00 arrangements with suppliers of services? If yes, see instructions. 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 36 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended exis	21.00		IN IN		ĮN.		21.00
Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 It is considered to the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 23.00 Have make a considered to the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 25.00 Have new leases and/or memediaments to existing leases entered into during this cost reporting period? N 24.00 Were new leases and/or memediaments to existing leases entered into during this cost reporting period? If yes, see Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 25.00 Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Mes the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Mes the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Mes the provider's period of the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 28.00 Mes acx string debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions of the provider hased Physicians of the provider for services? If yes, see instructions of the provider must be provider depreciations. 33.00 If I in 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 32.00 Mes environments and the provider facility under an arrangement with the provider-based Physicians of the provider facility under an arrangement with the provider-base		,	•				
Capital Related Cost Cost		COMPLETED BY COST DELMBURGED AND TEEDA HOODITALS ONLY (EVO	DEDT OUL DRENG	LIOCDI TAL C)		1. 00	
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost		,	EPI CHILDRENS	HUSPI TALS)			
reporting period? If yes, see instructions. 24.00 Were new leases subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 25.00 Have new capitalized leases entered into during the cost reporting period? If yes, see instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 32.00 Has debt been recalled before scheduled maturity wit	22. 00		ee instructions			N	22.00
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions account? If yes, see instructions (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled muturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 30.00 instructions. 32.00 Has debt been recalled before scheduled muturity without issuance of new debt? If yes, see instructions. 32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 33.00 If ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 instructions. 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 if yes, see instructions. 35.00 Were home office costs claimed on the cost report? N 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? N 37.00 if yes, see instructions. 37.00 If line 36 is yes, was the fiscal year end of the home office? N 37.00 if yes, see instructions. 38.00	23. 00		e due to apprai	sals made duri	ng the cost	N	23. 00
If yes, see instructions 25.00 Instructions 25.00 Instructions. 25.00 Instructions. 26.00 Instructions. 27.00 Instructions. 27	24.00		and into duning	this cost non	anting nariad?	NI.	24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit November 27.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) November 29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity with new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see November 29.00 Has debt been recalled before scheduled has de	24.00		ed Thto during	this cost rep	orting period?	IN	24.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 CODY. 10 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 31.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions. 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 1.00 Verbase N 35.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 instructions.	25. 00		g the cost repo	rting period?	If yes, see	N	25. 00
instructions. 27.00 But the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Vere new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Vere new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Vere new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Vere new loans, mortgage agreements or letters of credit entered into during the cost reporting 30.00 Vere services as a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 31.00 Vere services provider before scheduled maturity without issuance of new debt? If yes, see 32.00 Vere services 33.00 Vere new agreements occurred in patient care services furnished through contractual 33.00 Vere new agreements occurred in patient care services furnished through contractual 33.00 Vere new agreements occurred in patient care services furnished through contractual 33.00 Vere services furnished at the provider? Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Vere services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 Vere services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 Vere services furnished at the provider facility under an arrangement with provider-based physicians? 36.00 Vere services furnished at the provider facility under an arrangement with provider-based physicians? 37.00 Vere services furnished at the provider facility under an arrangement with provider-based physicians? 38.00 Ver	0.4.00						0, 00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions at funded to the cost report of the set of the cost report of the cost report of the cost of the cost of the cos	26.00		rne cost report	ing perioa? it	yes, see	N	26.00
Interest Expense	27.00		ne cost reporti	ng period? If	yes, submit	N	27.00
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 N 1 If line 32 is yes, were there new agreements or amended existing agreements with the provider-based physicians? Y 34.00 Were services furnished at the provider facility under an arrangement with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, was the fiscal year end of the home office. 38.00 If line 36 is yes, wearter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.		copy.	·				
period? If yes, see instructions. 29.00 by the provider have a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	20 00	Interest Expense	ntorod into du	ring the cost	roporting	N	20 00
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Instructions. N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 N N N N N N N N N	20.00		entered filto da	iring the cost	reporting	IN.	20.00
30. 00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31. 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32. 00 Have changes or new agreements occurred in patient care services furnished through contractual N 32. 00 Have changes or new agreements of sec. 2135. 2 applied pertaining to competitive bidding? If N 33. 00 If line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N 33. 00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34. 00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34. 00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 36. 00 Were home office costs claimed on the cost report? 37. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 38. 00 If line 36 is yes, was the fiscal year end of the home office? 39. 00 If line 36 is yes, enter in column 2 the fiscal year end of the home office. 39. 00 If line 36 is yes, did the provider render services to other chain components? If yes, see Instructions. 40. 00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40. 00 If line 36 is yes, did the provider render services to the home office? If yes, see N	29. 00	Did the provider have a funded depreciation account and/or		ebt Service Re	serve Fund)	N	29. 00
instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 Were home office Costs 36.00 Were home office costs claimed on the cost report? N 36.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of N 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, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.	20.00						20.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 N	30.00		turity with new	debt? IT yes,	see	IN IN	30.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs 4.00 Were home office costs claimed on the cost report? 36.00 Were home office costs share a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office. 39.00 If line 36 is yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.	31.00		ssuance of new	debt? If yes,	see	N	31.00
32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs							
arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs	32 00		rvices furnish	ed through con	tractual	N	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 15.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Available	32.00			ea through con	ti actuai	IV.	32.00
Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs	33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	N	33.00
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. N							
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs	34.00		arrangement wi	th provider-ba	sed physicians?	Y	34.00
physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00		,	arrangement in		py		
Home Office Costs Home Office Costs 1.00 2.00	35. 00			nts with the p	rovi der-based	N	35. 00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00		physicians during the cost reporting period? If yes, see i	nstructions.		V/N	Date	
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.							
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00							
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00			renared by the	home office?			1
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00	37.00		n epared by the	nome office?	IN		37.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N	38. 00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	N		38. 00
see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 1.00 2.00	20.00				N.I		30.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.	39.00		iei chain compo	nents/IT yes,	N		39.00
1.00 2.00	40. 00		e home office?	If yes, see	N		40.00
		i nstructi ons.	1				
			1	00	2	00	
		Cost Report Preparer Contact Information	1.		2.		
41.00 Enter the first name, last name and the title/position SHAWN ADAMS 41.00	41. 00	Enter the first name, last name and the title/position	SHAWN		ADAMS		41.00
held by the cost report preparer in columns 1, 2, and 3,		, , ,					
respectively. 42.00 Enter the employer/company name of the cost report ALLIANT MANAGEMENT SERVICES 42.00	42 00		ALLIANT MANAGE	MENT SERVICES			42 00
preparer.	00		12.1	22 320			
43.00 Enter the telephone number and email address of the cost 5029923508 SADAMS@BLUEANDCO.COM 43.00	43. 00	·	5029923508		SADAMS@BLUEAND	CO. COM	43.00
report preparer in columns 1 and 2, respectively.		report preparer in columns I and 2, respectively.	I		I		II

Health Financial Systems WABASH GENERAL N	HOSPITAL DISTRICT	In Lieu of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1327	Peri od: Worksheet S-	2
		From 01/01/2023 Part II To 12/31/2023 Date/Time Pro	oparod:
		5/17/2024 11	: 02 am_
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	MANAGER		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			42.00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

Provider CCN: 14-1327

Peri od:

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

33.01

0 34.00

From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am I/P Days / 0/P Visits / Tri ps CAH/REH Hours Component Worksheet A No. of Beds Bed Days Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 25 9, 125 38, 448. 00 1.00 0 8 exclude Swing Bed, Observation Bed and 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 HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 25 9, 125 7.00 38, 448, 00 0 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 25 9.125 38, 448. 00 0 14.00 15.00 CAH visits 0 15.00 15. 10 REH hours and visits 0.00 0 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 88.00 26 00 0 26 00 RURAL HEALTH CLINIC II 88.01 26.01 0 26.01 26. 02 RURAL HEALTH CLINIC III 88.02 0 26.02 26.03 RURAL HEALTH CLINIC IV 88.03 0 26.03 RURAL HEALTH CLINIC V 88. 04 0 26 04 26 04 RURAL HEALTH CLINIC VI 26.05 88.05 0 26.05 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 25 27.00 Observation Bed Days O 28 00 28 00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 32.01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

30.00

0

33.01

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

 Heal th Financial
 Systems
 WABASH GENERAL
 HOSPITAL
 DISTRICT

 HOSPITAL
 AND HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CCN

Provider CCN: 14-1327

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/17/2024 | 11: 02 am

		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	gui val ents	OZ alli
						•	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	2.22					
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 147	5	1, 602			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)	407					
2.00	HMO and other (see instructions)	187	65				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0 448	0	448			4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	440	0	137			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 595	5	2, 187	1		7.00
7.00	beds) (see instructions)	1,070	J	2, 107			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)	1, 595	5	2, 187		405. 94	
15.00	CAH visits	0	0	0			15.00
15. 10 16. 00	REH hours and visits	0	0	0			15. 10
17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF						16. 00 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						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	459	0	3, 376		1. 34	
26. 01	RURAL HEALTH CLINIC II	1, 539	0	11, 512		21. 70	
26. 02 26. 03	RURAL HEALTH CLINIC III RURAL HEALTH CLINIC IV	3, 878	0	5, 981		8. 44 9. 31	
26. 03	RURAL HEALTH CLINIC IV	2, 941 2, 621	0	7, 289 4, 532		9. 31	
26. 05	RURAL HEALTH CLINIC VI	1, 423	0	3, 749		8. 01	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	1, 423	0	3, 747		0.00	
27. 00	Total (sum of lines 14-26)		Ĭ	Č	0.00	464. 55	
28. 00	Observation Bed Days		o	205			28. 00
29.00	Ambul ance Trips	747					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			O			31.00
32. 00	Labor & delivery days (see instructions)	0	0	O			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
00.0-	outpatient days (see instructions)	_					00.00
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0	0	O			33. 01 34. 00
34.00	Temporary Expansion Covid-19 File Acute Care	١	Ч	U	1 1		J 34. 00

Health Financial SystemsWABASH GENEHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 14-1327

PART - STATISTICAL DATA						12/31/2023	5/17/2024 11:	
Component					Di sch	arges		
PART I - STATISTICAL DATA		Component		Title V	Title XVIII	Title XIX	Total All	
PART I - STATISTICAL DATA								
1.00 Hospital Adult is & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 7 or the portion of LDP room available beds) 2.00 HMO and other (see Instructions) 45 19 2.00 3.00 4.00 HMO IRF Subprovi der 0 4.0		DART I CTATICTICAL DATA	11. 00	12. 00	13.00	14.00	15.00	
B exclude Swing Bed, Observation Bed and Hospite deays) (see instructions for cot. 2 for the portion of LDP room available beds)	1 00			0	225	1	190	1 00
Hospice days)(See instructions for col. 2 For the portion of LDP room avail able beds) 2.00 Mol and other (see instructions) 3.00 Mol IPF Subprovider 0 3.00 3.00 Mol IPF Subprovider 0 4.00	1.00			0	323	'	400	1.00
For the portion of LDP room available beds) 3.00 3.00 4.0								
3.00 HMO IPF Subprovi der 4.00 HMO IPF Subprovi der 5.00 Hospit al Adult s. & Peds. Swing Bed NF 6.00 Hospit al Adult s. & Peds. Swing Bed NF 7.00 Total Adult s. and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 ORDONARY CARE UNIT 10.00 SURGI CAL, INTENSIVE CARE UNIT 11.00 SURGI CAL, INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NUSSERY 15.00 CAHO vi si ts 16.00 SUBPROVI DER - IRF 17.00 SURGINER FACILITY 18.00 SUBPROVI DER - IRF 18.00 SUBPROVI DER - IRF 18.00 ON SURGINER FACILITY 19.00 THER LONG TERM CARE 19.00 AMBULATORY SURGI CAL CENTER (D. P.) 20.00 AMBULATORY SURGI CAL CENTER (D. P.) 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 24.10 HOSPI CE (non-di stinct part) 25.00 CAMO RURAL HEALTH CLINI C II 26.01 RURAL HEALTH CLINI C II 26.02 RURAL HEALTH CLINI C II 27.00 CAHO CAHO CHARLE CALL CHINI C II 28.00 CON PROSPI CE (Non-di stinct part) 29.00 CON PROSPI LIBER (NON-DI STOR PART PART PART PART PART PART PART PAR								
HMO IRF Subprovi der	2.00	HMO and other (see instructions)			45	19		2.00
5.00 Hospital Adults & Peds. Swing Bed NF 6.00 February								
Bospital Adults & Peds. Swing Bed NF		•				0		
Total Adults and Peds. (exclude observation bodd) (see instructions) R. 00								
beds) (see instructions)								
8.00 INTENSIVE CARE UNIT	7. 00	`						7. 00
9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00	0 00							9 00
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1								
11. 00 SURGICAL INTENSIVE CARE UNIT								
12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 12.00 13.00 NURSERY 14.00 Total (see instructions) 0.00 0 325 1 480 14.00 15.00 CAH visits								
13.00 NURSERY								
15.00 CAH visits								
15. 10 REH hours and visits	14.00	Total (see instructions)	0.00	0	325	1	480	14.00
16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 17.00 18.00 17.00 18.00 19.00 SKILLED NURSING FACILITY 19.00	15.00	CAH visits						15.00
17.00 SUBPROVI DER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 0 0 0 0 0 0 0 0 0		REH hours and visits						15. 10
18. 00 19								
19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC II 26. 00 RURAL HEALTH CLINIC III 26. 01 RURAL HEALTH CLINIC IV 26. 02 RURAL HEALTH CLINIC IV 26. 03 RURAL HEALTH CLINIC IV 26. 04 RURAL HEALTH CLINIC V 26. 05 EVERALLY OUALIFIED HEALTH CENTER 26. 05 EVERCHALLY OUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 19. 00 20. 00 Valore Care 21. 00 22. 00 22. 00 22. 00 23. 00 24. 10 25. 00 26. 01 26. 02 26. 03 27. 00 28. 00 29.								
20. 00 NURSING FACILITY 20. 00 21. 00 21. 00 22. 00 22. 00 23. 00 24. 00 40. MBULATORY SURGICAL CENTER (D.P.) 22. 00 40. MBULATORY SURGICAL CENTER (D.P.) 24. 00 40. SPICE 24. 10 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 01 26. 02 26. 03 26. 04 26. 04 26. 04 26. 05 26		1						
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 26. 04 RURAL HEALTH CLINIC IV 26. 05 RURAL HEALTH CLINIC V 26. 06 RURAL HEALTH CLINIC V 26. 07 RURAL HEALTH CLINIC V 26. 08 RURAL HEALTH CLINIC V 26. 09 COO 26. 00 RURAL HEALTH CLINIC V 26. 00 AUGUST V 26. 00 RURAL HEALTH CLINIC V 26. 00 OO 26. 00 RURAL HEALTH CLINIC V 26. 00 OO 26. 00 RURAL HEALTH CLINIC V 26. 00 OO 26. 00 RURAL HEALTH CLINIC V 26. 00 OO 27. 00 OO 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTOH non-covered days 0 O Sassible V 29. 00 August on Company outpatient days (see instructions) 33. 00 LTOH non-covered days		1						
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 44. 00 HOSPICE HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 04 RURAL HEALTH CLINIC IV 26. 05 RURAL HEALTH CLINIC IV 26. 07 RURAL HEALTH CLINIC V 26. 08 RURAL HEALTH CLINIC V 26. 09 COO 26. 01 RURAL HEALTH CLINIC V 26. 02 RURAL HEALTH CLINIC V 26. 03 RURAL HEALTH CLINIC V 26. 04 RURAL HEALTH CLINIC V 26. 05 COO 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 33. 00 LTCH non-covered days								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 0.00 26.01 RURAL HEALTH CLINIC III		1						
24.00 HOSPICE								
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC		, ,						
26. 00 RURAL HEALTH CLINIC 0. 00 26. 01 26. 00 26. 01 26. 01 26. 01 26. 01 26. 02 RURAL HEALTH CLINIC III 0. 00 26. 03 RURAL HEALTH CLINIC IV 0. 00 26. 04 RURAL HEALTH CLINIC V 0. 00 26. 05 RURAL HEALTH CLINIC V 0. 00 26. 05 RURAL HEALTH CLINIC V 0. 00 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 29. 00 Ambul ance Trips 29. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 33. 00 33. 00		HOSPICE (non-distinct part)						24. 10
26. 01 RURAL HEALTH CLINIC III	25.00	CMHC - CMHC						25.00
26. 02 RURAL HEALTH CLINIC III								
26. 03 RURAL HEALTH CLINIC IV 0. 00 26. 04 RURAL HEALTH CLINIC V 0. 00 26. 05 RURAL HEALTH CLINIC V 0. 00 26. 05 RURAL HEALTH CLINIC VI 0. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 0.			l l					
26. 04 RURAL HEALTH CLINIC V 26. 05 RURAL HEALTH CLINIC VI 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 26. 05 26. 05 26. 05 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 00 32. 01 33. 00 33. 00 33. 00								
26. 05 RURAL HEALTH CLINIC VI 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 26. 05 26. 25 27. 00 28. 00 29.								
26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 26. 25 27. 00 0. 00 28. 00 0. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 01 32. 01 33. 00 33. 00								
27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 0bservation Bed Days 28.00 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 23.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00								
28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 28.00 29.00 30.00 30.00 30.00 31.00 31.00 32.00 32.01								
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 29.00 30.00 31.00 31.00 31.00 32.01 32.01			0.00					
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 32.00 32.01 32.01		1						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 32.01	30.00	Employee discount days (see instruction)						30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01								
outpati ent days (see instructions) 33.00 LTCH non-covered days 0 33.00		3 3 1						
33.00 LTCH non-covered days 0 33.00	32. 01							32. 01
	22.00							22.00
34. 00 Temporary Expansi on COVID-19 PHE Acute Care								

103F1	n Financial Systems WAR TAL-BASED RHC/FOHC STATISTICAL DATA	SASH GENERAL H	OSPITAL DISTRI	CCN: 14-1327	Peri		u of Form C Worksheet		352-10
	TAL-BASED KNC/FUNC STATISTICAL DATA					n 01/01/2023			
			Component	CCN: 14-8501	То	12/31/2023			
						RHC I	5/17/2024 Cos)2 am
						KIIO I	00.		
						1. (00		
	Clinic Address and Identification								
. 00	Street		1		14	18 COLLEGE DI			1.00
				<u>i ty</u> . 00		State 2.00	ZIP Code	•	
. 00	City, State, ZIP Code, County		MT. CARMEL	. 00			3. 00 62863		2.00
. 00	jorty, state, zir sode, sodinty		mir. Ortimee			1 -	02000		2.0
							1. 00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for ru	ral or "U" for					0	3.0
				Gra	nt Av		Date		
	Source of Federal Funds				1.00		2. 00		
. 00	Community Health Center (Section 330(d), PHS	Act)							4.00
. 00	Migrant Health Center (Section 329(d), PHS A								5. 00
. 00	Health Services for the Homeless (Section 34)						6.0
00	Appalachian Regional Commission								7. 0
00	Look-Alikes								8.0
00	OTHER (SPECIFY)								9.0
01 02									9.0
02									9. C
04									9.0
05									9.0
. 06									9.0
. 07									9. 0
. 08									9. 0
. 09									9. 0 ^o
. 10									
	<u> </u>								7
				•		1. 00	2. 00		7
	Does this facility operate as other than a h	nospi tal -based	RHC or FQHC? I	Enter "Y" for		1. 00 N	2. 00	0	
0. 00	yes or "N" for no in column 1. If yes, indic	ate number of	other operation	ons in column			2. 00	0	
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of	ate number of	other operation	ons in column			2.00	0	
	yes or "N" for no in column 1. If yes, indic	cate number of of other opera	other operation tion(s) and the	ons in column e operating		N		0	
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of	cate number of of other opera	other operation	ons in column e operating		N	2.00 Tuesday from	0	
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type of hours.)	cate number of of other operat	other operation (s) and the nday	ons in column e operating		N y	Tuesday	0	
0. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1)	sate number of other operations Sulfrom 1.00	other operation of the	ons in column e operating from 3.00	Monda	N y to 4.00	Tuesday from 5.00	0	10.00
0. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1)	cate number of other operations Suite from	other operation of the other operation	ons in column e operating from	Monda	N y to 4.00	Tuesday from	0	10.00
0. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1)	sate number of other operations Sulfrom 1.00	other operation of the	ons in column e operating from 3.00	Monda	N to 4.00	Tuesday from 5.00	0	10.0
1. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC	sate number of other operations of other opera	other operation of the	ons in column operating from 3.00	Monda	N to 4.00 :00	Tuesday from 5.00	0	10. 0
1. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception of the column in the	sate number of other operation of other operation of summer of the summer of summer of other operations. Summer of the summer of other operations of the summer of other operations of the summer of other operations.	other operation of the other operation operation of the other operation oper	ons in column operating from 3.00 15:00	Monda 21	N to 4.00 : 00 1.00 N	Tuesday from 5.00	0	11. 0
1. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception of the column in the	sate number of other operations of other operations of the proceed in CMS Pub.	other operation of the	ons in column operating from 3.00 15:00 dard? er 9, section	Monda 21	N to 4.00 :00	Tuesday from 5.00		11. 0
1. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception of the subscripts of line and	sate number of other operations of other operations of the proceed in CMS Pub. umn 1. If yes,	other operation of the other operation operation of the other operation operation of the other operation	ons in column operating from 3.00 15:00 dard? er 9, section umn 2 the	Monda 21	N to 4.00 : 00 1.00 N	Tuesday from 5.00		11. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception 1s this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	sate number of other operation of other operation of the proceed in CMS Pub. List the name	other operation of the operation of the one of the other operation operation of the other operation ope	ons in column operating from 3.00 15:00 dard? er 9, section umn 2 the ders and	Monda:	N to 4.00 ::00	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception list his a consolidated cost report as define 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 report.	sate number of other operation of other operation of the proceed in CMS Pub. umn 1. If yes, List the name ing multiple of the other of the process of the other operations of the process of the other operations of the process of the other operations of the other operatio	other operation of the operation of the one of the other operation operation of the other operation of the other operation operation operation operation operation of the other operation operatio	ons in column operating from 3.00 15:00 dard? er 9, section umn 2 the ders and dCs (as defin	Monda 21	N to 4.00 : 00 1.00 N	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as define 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 report in CMS Pub. 100-02, chapter 13, section 80.2	sate number of other operations of other operations on the proceed in CMS Publication on the number of the number	other operation of the	ons in column or operating from 3.00 15:00 dard? er 9, section umn 2 the ders and dCS (as definition of the column 1 for no. If	Monda 21	N to 4.00 ::00	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exceptil s this a consolidated cost report as define 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 report in CMS Pub. 100-02, chapter 13, section 80. 2 yes, enter in column 2 the number of consoli	ate number of other operations of other operations on the proceed in CMS Pub. umn 1. If yes, List the name ting multiple of the control of the process of the control of the control of the control of the process of the control of th	other operation of the	ons in column of operating from 3.00 15:00 dard? er 9, section of the ders and de	Monda 21	N to 4.00 ::00	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as define 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 report in CMS Pub. 100-02, chapter 13, section 80.2	sate number of other operations of other operations of the proceed in CMS Pub. umn 1. If yes, List the name of the process of	other operation of the operation of the one of the other operation of the other operation of the other operations of the other	ons in column operating from 3.00 15:00 dard? er 9, section of the ders and	Monda 21	N to 4.00 ::00	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
1. 00 2. 00 3. 00	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exceptil s this a consolidated cost report as define 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 report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated separate Worksheet S-8 for each consolidated.	sate number of other operations of other operations of the proceed in CMS Publicum 1. If yes, List the name of the proceed of	other operation of the	ons in column operating from 3.00 15:00 dard? er 9, section of the ders and	Monda 21	N to 4.00 ::00	Tuesday from 5.00	0	10. 0 11. 0 12. 0 13. 0
	yes or "N" for no in column 1. If yes, indice 2. (Enter in subscripts of line 11 the type of hours.) Facility hours of operations (1) CLINIC Have you received an approval for an exception list this a consolidated cost report as define 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 report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated are consolidated are comprised exclusively of grandfathered consolidated are cons	sate number of other operations of other operations of the proceed in CMS Publicum 1. If yes, List the name of the proceed of	other operation of the	dard? er 9, section umn 2 the ders and HCs (as define) for no. If old RHC grouping uping or	Monda 21	N	Tuesday from 5.00	0	10. 00 11. 00 12. 00 13. 00

Health Financial Systems WAB	BASH GENERAL HO	OSPITAL DISTRIC	T	In Lieu of Form CMS-2552		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8501	From 01/01/2023 To 12/31/2023		epared: 02 am
				RHC I	Cost	
	Y/N	V	XVIII	XIX	Total Visits	
	1. 00	2. 00	3.00	4. 00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		Col	ıntv			15.00
			00			
2.00 City, State, ZIP Code, County		WABASH	-			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	21: 00	18: 00	21: 00		21: 00	11. 00
		day		turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)	1	1	,			
11. 00 CLINIC	15: 00	21: 00	10: 00	22: 00		11.00

		ASH GENERAL HO				eu of Form C		552-1
HOSPI T	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Period: From 01/01/202:	Worksheet	S-8	
			Component	CCN: 14-8568	To 12/31/202			
					RHC II	Co:		72 aiii
	Clinic Address and Identification				1	. 00		
1. 00	Street				1123 CHESTNUT	STREET		1.00
				ty	State	ZIP Code	•	
2 00	City Ctata 71D Cada Causty			00	2. 00	3.00		2.00
2. 00	City, State, ZIP Code, County		MOUNT CARMEL			L 62863-1212		2.00
						1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter	er "R" for rur	al or "U" for				0	3.00
					nt Award 1.00	2. 00		
	Source of Federal Funds				1.00	2.00		
4.00	Community Health Center (Section 330(d), PHS	Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad							5.00
6. 00 7. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	O(d), PHS Act)						6. 00 7. 00
8. 00	Look-Alikes							8. 00
9. 00	OTHER (SPECIFY)							9. 00
					1.00			
10.00	Does this facility operate as other than a ho	nsni tal _hased	RHC or FOHC2 F	nter "V" for	1. 00 N	2.00	0	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)	ate number of	other operatio	ns in column				10.00
	illoui S.)	Sun	day	l N	londay	Tuesday		
		from	to	from	to	from		
	[5t] [1t] [1t] [1t]	1. 00	2. 00	3. 00	4. 00	5.00		
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00		11. 00
11100	joerni, s			100.00	177.00	00.00		
					1. 00	2. 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 columburation of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N		0	12. 00 13. 00
13. 01	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 RHG)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping			0	13. 0
					ider name	CCN		
14 00	RHC/FQHC name, CCN				1. 00	2.00		14. 00
14.00	KIIC/T QIIC Hallie, CCN	Y/N	V	XVIII	XIX	Total Visi	ts	14.00
		1. 00	2.00	3. 00	4. 00	5. 00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00

Health Financial Systems W.	ABASH GENERAL HO	OSPITAL DISTRIC	T	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8568	From 01/01/2023 To 12/31/2023		epared: 02 am
				RHC II	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		WABASH				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	17: 00	08: 00	17: 00	08: 00	18: 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 CLINIC	08: 00	17: 00				11.00

		ASH GENERAL HO				eu of Form (2552-10
HOSPI I	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od: From 01/01/202	Worksheet	S-8	
			Component	CCN: 14-8579	To 12/31/202	3 Date/Time 5/17/2024		
					RHC III	Co		JZ alli
	Clinic Address and Identification					. 00		
1. 00	Street				1418 COLLEGE	DR	\neg	1.00
				ty	State	ZIP Code)	
2. 00	City, State, ZIP Code, County		MOUNT CARMEL	00	2.00	3. 00 L 62863		2.00
2.00	city, State, Zir code, county		INIOUNT CARNILL			L 02003		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for run	al or "U" for		n+ Award	Doto	0	3.00
				Gra	nt Award 1.00	2.00		
	Source of Federal Funds					2.00		
4.00	Community Health Center (Section 330(d), PHS							4.00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340							5. 00 6. 00
7. 00	Appal achi an Regional Commission	o(d), This Act)						7. 00
8. 00	Look-Alikes							8.00
9. 00	OTHER (SPECIFY)							9. 00
					1. 00	2.00		
10. 00	Does this facility operate as other than a ho						0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)							
	illoui 3.)	Sun	day	N	londay	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: 00	17: 00	08: 00		11.00
				•				
12 00	Have you received an approval for an eventi-	n +a +ba nrad	uativity atana	landO	1. 00 N	2.00		12.00
	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.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the			0	12. 00 13. 00
13. 01	numbers below. If line 13, column 1, is "Y", are you reporti	ng multiple c	onsolidated RH	lCs (as defin			0	13. 01
	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 comprised exclusively of new consolidated RHG	dated RHC grou RHC grouping. onsolidated RH	pings and comp Consolidated Cs in the grou	lete a I RHC groupin				
	, see some der ver y or non consort dated him	gi ou	F91	Prov	ider name	CCN		
11.00	Taua (5010				1. 00	2. 00		
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visi	ts.	14.00
		1. 00	2.00	3.00	4.00	5. 00	13	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15. 00

Health Financial Systems W.	ABASH GENERAL HO	OSPITAL DISTRIC	T	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8579	From 01/01/2023 To 12/31/2023		epared: 02 am
				RHC III	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		WABASH				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	17: 00	08: 00	17: 00	08: 00	17: 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 CLINIC	08: 00	17: 00				11.00

		ASH GENERAL HO				eu of Form C		552-10
HOSPI 1	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Period: From 01/01/202	Worksheet	S-8	
			Component	CCN: 14-8599	To 12/31/202	3 Date/Time		
					RHC IV	5/17/2024 Co		JZ alli
			-					
	Olinia Adduses and Identification				1	. 00		
1. 00	Clinic Address and Identification Street				1106 OAK STRE	FT		1. 00
1.00	1511 661		Ci	ty	State	ZIP Code	,	1.00
				00	2.00	3. 00		
2. 00	City, State, ZIP Code, County		MOUNT CARMEL			L 62863		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter	er "R" for rur	al or "U" for				0	3.00
					nt Award	Date		
	Source of Federal Funds				1. 00	2. 00		
4. 00	Community Health Center (Section 330(d), PHS	Act)						4.00
5. 00	Migrant Health Center (Section 329(d), PHS Ad							5.00
6. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)						6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9. 00
10.00	Does this facility operate as other than a ho	neni tal _hased	PHC or FOHC2 F	nter "V" for	1. 00 N	2. 00	0	10.00
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	other operatio	ns in column				10.00
	Tiour S.)	Sun	day	l N	londay	Tuesday		
		from	to	from	to	from		
	Facility hours of aparetions (1)	1. 00	2. 00	3.00	4. 00	5. 00		
11. 00	Facility hours of operations (1)			08: 00	17: 00	08: 00		11. 00
	1			100.00				
	In the second second				1.00	2. 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 columnumber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N		0	12.00 13.00
13. 01	numbers below. If line 13, column 1, is "Y", are you reporti in 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 RHG)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping			0	13. 0
					ider name	CCN		
14 00	RHC/FOHC name, CCN				1. 00	2. 00		14. 00
14.00	MIO/T QUO Halle, CON	Y/N	V	XVIII	XIX	Total Visi	ts	14.00
		1. 00	2.00	3. 00	4. 00	5. 00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00

Health Financial Systems W	ABASH GENERAL HO	SPITAL DISTRIC	Т	In Lie	In Lieu of Form CMS-25		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od:	Worksheet S-8	3	
		Component	CCN: 14-8599	From 01/01/2023 To 12/31/2023		epared: 02 am	
				RHC IV	Cost		
		Cou	inty				
		4.	00				
2.00 City, State, ZIP Code, County		WABASH				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	17: 00	08: 00	17: 00	08: 00	17: 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 CLINIC	08: 00	17: 00				11.00	

		ASH GENERAL HO				eu of Form C		552-1
HOSPI 1	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od: From 01/01/202	Worksheet	S-8	
			Component	CCN: 14-8601	To 12/31/202	3 Date/Time		
					RHC V	5/17/2024 Co		JZ alli
	Clinia Address and Identification				1	. 00		
1. 00	Clinic Address and Identification Street				26 EAST ELM S	TREET		1. 00
1. 00	1511 661		Ci	ty	State	ZIP Code	,	1.00
				00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County		ALBI ON			L 62806		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter	er "R" for rur	al or "U" for	urban			0	3.00
				Gra	nt Award	Date		
	Source of Federal Funds				1. 00	2. 00		
4. 00	Community Health Center (Section 330(d), PHS	Act)						4.00
5. 00	Migrant Health Center (Section 329(d), PHS Ad							5.00
6. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)						6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9. 00
10.00	Door this facility energic as other than a h	acni tal bacad	DUC on FOUCA F	nton "V" for	1. 00 N	2.00	0	10.00
10.00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)	ate number of	other operatio	ns in column			U	10.00
	Tiour 3.)	Sun	day	l N	Monday	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: 00	17: 00	08: 00		11.00
				1				
10.00					1.00	2. 00		40.00
	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. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N		0	12. 00 13. 00
13. 01	If line 13, column 1, is "Y", are you reporting the 13, column 1, is "Y", are you reporting the 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 comprised exclusively of new consolidated RHC)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC groupin			0	13. 0
				Prov	ider name	CCN		
14 00	RHC/FOHC name, CCN				1. 00	2. 00		14. 00
14.00	RRC/FURC Hallie, CCN	Y/N	V	XVIII	XIX	Total Visi	ts	14.00
		1. 00	2.00	3.00	4. 00	5. 00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00

Health Financial Systems WA	BASH GENERAL H	OSPITAL DISTRIC	T	In Lie	2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1327	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8601	From 01/01/2023 To 12/31/2023		epared: 02 am
				RHC V	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		EDWARDS				2. 00
	Tuesday	Wedn	esday	Thursday		
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	09: 00	18: 00	11.00
	Fri	i day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	16: 00				11.00

		ASH GENERAL H	OSPITAL DISTRI			eu of Form (2552-10
HOSPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1327	Period: From 01/01/202:	Worksheet	S-8	
			Component	CCN: 14-8613	To 12/31/2023	3 Date/Time 5/17/2024		
					RHC VI	Co		JZ alli
	Clinic Address and Identification				1	. 00		
1. 00	Street				610 N COURT S	Т	\neg	1.00
				i ty	State	ZIP Code)	
2. 00	City, State, ZIP Code, County		GRAYVI LLE	. 00	2.00	3. 00 L 62844		2.00
2.00	crity, State, 217 code, county		GRATVILLE		11	L 02044		2.00
						1. 00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for ru	ral or "U" for		n+ Award	Doto	0	3.00
				Gra	nt Award 1.00	2.00		
	Source of Federal Funds					2.00		
4.00	Community Health Center (Section 330(d), PHS							4.00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340)					5. 00 6. 00
7. 00	Appal achi an Regional Commission	o(d), The Act	,					7. 00
8. 00	Look-Alikes							8. 00
9. 00	OTHER (SPECIFY)							9.00
					1. 00	2.00		
10. 00	Does this facility operate as other than a ho						0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)							
	nodi 3.)	Su	nday	l N	Monday	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00		
11. 00		10: 00	22: 00	15: 00	21: 00	15: 00		11.00
12 00	Have you received an approval for an exception	on to the pro-	ductivity stan	land?	1. 00 N	2. 00		12. 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.	d in CMS Pub. umn 1. If yes,	100-04, chapte , enter in colu	er 9, section umn 2 the			0	13. 00
13. 01	numbers below. If line 13, column 1, is "Y", are you reportin CMS Pub. 100-02, chapter 13, section 80.2	ing multiple (consolidated R	HCs (as defin			0	13. 0 ⁻
	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 RHG	RHC grouping. onsolidated R	. Consolidated HCs in the grou	d RHC groupin	gs			
				Prov	ider name	CCN		
14 00	DUC/FOUC TOTAL CON				1. 00	2. 00		14.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visi	ts	14. 00
		1. 00	2.00	3.00	4.00	5. 00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15. 00

Health Financial Systems W	ABASH GENERAL H	OSPITAL DISTRIC	CT	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 14-1327	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8613	From 01/01/2023 To 12/31/2023		epared: 02 am
				RHC VI	Cost	
		Cou	unty			
		4.	.00			
2.00 City, State, ZIP Code, County		EDWARDS				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	21: 00	18: 00	21: 00	18: 00	21: 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 CLINIC	15: 00	21: 00	10: 00	22: 00		11.00

Heal th	Financial Systems	WABASH GENERAL HOSPI	TAL DISTRIC	Т	In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC		Peri od: From 01/01/2023	Worksheet S-1	0 pared:
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX D	ΔΤΔ				1.00	
	Uncompensated and Indigent Care Cost-to-						1
1.00	Cost to charge ratio (see instructions)	onar go narro				0. 381424	1.00
	Medicaid (see instructions for each line	9)					1
2.00	Net revenue from Medicaid					13, 542, 391	2.00
3.00	Did you receive DSH or supplemental paym	ments from Medicaid?				Υ	3.00
4.00	If line 3 is yes, does line 2 include al	I DSH and/or suppleme	ntal payment	ts from Medic	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or s	supplemental payments	from Medicai	d		0	5.00
6.00	Medi cai d charges					32, 335, 352	
7. 00	Medicaid cost (line 1 times line 6)					12, 333, 479	
8. 00							8. 00
0.00	Children's Health Insurance Program (CHI	P) (see Instructions	ror each iir	ne)			0 00
9.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges					0	
	Stand-alone CHIP cost (line 1 times line	2 10)				0	
	Difference between net revenue and costs		(see instri	ictions)		0	
12.00	Other state or local government indigent				•)		12.00
13.00	Net revenue from state or Local indigent	t care program (Not in	cluded on li	nes 2, 5 or	9)	0	13.00
14. 00	Charges for patients covered under state 10)	e or local indigent ca	re program ((Not included	lin lines 6 or	0	14. 00
15.00	State or local indigent care program cos	st (line 1 times line	14)			0	15.00
16.00	Difference between net revenue and costs					0	16. 00
	Grants, donations and total unreimbursed instructions for each line)	· ·			gent care progra		
	Private grants, donations, or endowment						17.00
	Government grants, appropriations or tra					0	18. 00
19. 00	Total unreimbursed cost for Medicaid , (8, 12 and 16)	CHIP and state and loc	al indigent			0	19. 00
				Uni nsured	Insured	Total (col. 1	
				patients 1.00	pati ents 2.00	+ col . 2) 3.00	
	Uncompensated care cost (see instruction	ns for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured disco		s)	174, 0	52 0	174, 052	20.00
	Cost of patients approved for charity ca			66, 38			
	instructions)		·				
22. 00	Payments received from patients for amou	unts previously writte	n off as		0 0	0	22.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

66, 388

66, 388

0

1. 00

8, 039, 625

7, 202, 514

3, 040, 200

3, 106, 588

3, 106, 588 31.00

544, 123

837, 111

23.00

24.00

25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

charity care

stay limit

25.00

26.00

27.00

27.01

23.00 Cost of charity care (see instructions)

Bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

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

Medicare reimbursable bad debts (see instructions)

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

Medicare allowable bad debts (see instructions)

			To 12/31/2023	Date/Time Pre 5/17/2024 11:					
				1.00					
	PART II - HOSPITAL DATA			1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1				
1.00									
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				2.00				
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00					
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paym	cai d?		4.00					
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medi	ai d			5. 00				
6. 00	Medi cai d charges				6.00				
7. 00	Medicaid cost (line 1 times line 6)				7.00				
8. 00	Difference between net revenue and costs for Medicaid program (see ins				8. 00				
0.00	Children's Health Insurance Program (CHIP) (see instructions for each	i ne)		ı	0.00				
9.00	Net revenue from stand-al one CHIP				9.00				
10.00	Stand-alone CHIP charges				10.00				
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see ins	ructions)			11. 00 12. 00				
12.00	Other state or local government indigent care program (see instructions		رما		12.00				
13. 00	Net revenue from state or local indigent care program (Not included on				13.00				
14. 00	Charges for patients covered under state or local indigent care program				14.00				
14.00	10)	(Not Therade	d III IIIICS 0 01		14.00				
15. 00	State or local indigent care program cost (line 1 times line 14)		15.00						
16.00									
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and s	ate/local ind	ligent care progra	ams (see	1				
	instructions for each line)								
17.00	Private grants, donations, or endowment income restricted to funding c			17. 00					
18.00	Government grants, appropriations or transfers for support of hospital				18. 00 19. 00				
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines								
	8, 12 and 16)								
		Uni nsured		Total (col. 1					
		pati ents 1.00	pati ents 2.00	+ col . 2) 3.00					
	Uncompensated care cost (see instructions for each line)	1.00	2.00	3.00					
20.00	Charity care charges and uninsured discounts (see instructions)				20.00				
21. 00	Cost of patients approved for charity care and uninsured discounts (se	<u>.</u>			21.00				
21.00	instructions)				200				
22. 00	Payments received from patients for amounts previously written off as				22.00				
	charity care								
23.00	Cost of charity care (see instructions)				23.00				
				1. 00					
24. 00	Does the amount on line 20 col. 2, include charges for patient days be		of stay limit		24. 00				
	imposed on patients covered by Medicaid or other indigent care program				05.00				
25. 00	If line 24 is yes, enter the charges for patient days beyond the indig	ent care progr	am's length of		25. 00				
25 01	stay limit Charges for incurred national Liebility (see instructions)		DE 01						
25. 01	Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)			25. 01 26. 00					
26. 00 27. 00	Medicare reimbursable bad debts (see instructions)			27.00					
27. 00	Medicare allowable bad debts (see instructions)			27.00					
28. 00	Non-Medicare bad debt amount (see instructions)				28.00				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (s	e instruction	ıs)		29.00				
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		,		30.00				
	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00				
				•	•				

RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 14-1327	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	III NONGO T	
					To 12/31/2023		
	01.01	6.1	011	Talak (ask)	1 D 1	5/17/2024 11:	02 am
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2. 00	3.00	4. 00	<u>col. 4)</u> 5. 00	
	CENERAL CERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT		1 071 120	1, 871, 13	9 -347, 218	1 522 021	1 00
1.00			1, 871, 139				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	420.040	2, 979, 541			3, 107, 476	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	438, 968	1, 216, 965			1, 655, 933	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 693, 227	7, 680, 559			11, 002, 875	5.00
7.00	00700 OPERATION OF PLANT	373, 405	1, 984, 520	1		2, 478, 543	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0 F31 014	200 024		0 139, 102	139, 102	8.00
9.00	00900 HOUSEKEEPI NG	531, 816	289, 034			820, 850	9.00
10.00		553, 433	538, 133	1			10.00
11.00		(11 577	127 207		920, 160	920, 160	11.00
13.00		611, 577	127, 307			738, 884	13.00
16.00	1 1	498, 439	1, 140, 951			1, 637, 333	16.00
17.00	1 1	205, 690	67, 920			273, 610	17.00
19. 00		1, 373, 373	321, 139	1, 694, 51	2 -14, 796	1, 679, 716	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.000.005	4 (05 540	0 (07 75	0 000	0 (04 4/4	00.00
30. 00		2, 032, 205	1, 605, 548	3, 637, 75	3 -36, 292	3, 601, 461	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 400 770	F 000 070	7 000 05	4 000 705	0.050.05/	F0 00
50.00		1, 498, 779	5, 800, 072			2, 959, 056	50.00
53.00		0	0	l .	0 0	0	53.00
54.00	1 1	1, 080, 356	1, 479, 617			2, 556, 509	54.00
60.00	1	1, 176, 932	1, 934, 266			3, 096, 674	
65. 00		547, 106	188, 447			715, 879	65.00
65. 01	1	154, 301	53, 307	1		207, 608	
65. 02		78, 312	130, 923			209, 235	65. 02
65. 03	1	258, 521	111, 224			369, 745	65.03
66. 00		1, 742, 256	793, 200				66.00
71.00		275, 037	275, 712	1		1, 324, 651	71.00
72.00	1	0	0	1	0 3, 503, 508		72.00
73. 00		532, 758	5, 903, 220	6, 435, 97	8 -3, 381	6, 432, 597	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	105.070	4.40.005	054.00	0 55 000	240.070	00.00
88. 00		105, 063	149, 335				88. 00
88. 01		2, 346, 560	459, 812				88. 01
88. 02	1 1	1, 005, 896	230, 301			1, 228, 364	88. 02
88. 03		1, 095, 580	276, 802			1, 371, 301	88. 03
88. 04	1 1	718, 051	346, 004			1, 100, 345	88. 04
88. 05		574, 417	275, 777			873, 345	88. 05
90.00	1 1	618, 900	562, 399			1, 187, 690	90.00
90. 01	09001 ORTHOPAEDI C CLI NI C	5, 626, 170	1, 049, 276			6, 897, 644	90.01
90. 02	1 1	936, 806	533, 534			1, 460, 019	90.02
90. 03	1 1	826, 912	78, 780			912, 861	90.03
90. 04	1 1	159, 141	150, 911			320, 316	90.04
90.05	1 1	156, 114	558, 661			797, 547	90.05
91.00		1, 847, 629	2, 216, 203	4, 063, 83	2 -10, 637	4, 053, 195	
92. 00							92.00
05.00	OTHER REIMBURSABLE COST CENTERS	4 470 400		0.000.05	el oe 4541	0.405.407	
95.00	09500 AMBULANCE SERVICES	1, 478, 488	611, 767	2, 090, 25	5 95, 151	2, 185, 406	95.00
440.0	SPECIAL PURPOSE COST CENTERS				ما ما		
	0 11300 I NTEREST EXPENSE	05 450 040	0		0 0		113.00
118. 0		35, 152, 218	43, 992, 306	79, 144, 52	4 16, 159	79, 160, 683	118.00
466 -	NONREI MBURSABLE COST CENTERS	_1		ı	0 -1		100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	1 19201 OUTREACH	214, 483	88, 000			269, 383	192. 01
	2 19202 CLI NI C	757, 944	212, 789			987, 674	
200. 0	0 TOTAL (SUM OF LINES 118 through 199)	36, 124, 645	44, 293, 095	80, 417, 74	이	80, 417, 740	200.00

Health Financial Systems WAE	BASH GENERAL HO	SPITAL DISTRICT		In Lieu	of Form CMS-2552	2-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der CCN	l: 14-1327	Peri od:	Worksheet A	
				From 01/01/2023	D : (T) D	
				To 12/31/2023	Date/Time Prepare 5/17/2024 11:02 a	ed:
Cost Center Description	Adjustments	Net Expenses			3/1//2024 11.02 8	alli
cost center bescription	(See A-8)	For				
	(500 // 5)	Allocation				
	6. 00	7. 00				
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	0	1, 523, 921			1.	. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	-446, 887				2.	2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-202, 452					1. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-697, 709					5. 00
7.00 00700 OPERATION OF PLANT	0					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	1				3. 00
9. 00 00900 HOUSEKEEPI NG	0					0.00
10. 00 01000 DI ETARY	-15, 404					0.00
11. 00 01100 CAFETERI A	-239, 349					. 00
13.00 01300 NURSING ADMINISTRATION	0	738, 884				3. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-13, 028					. 00
17. 00 01700 SOCIAL SERVICE	0	273, 610				7. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	-1, 373, 373					9. 00
INPATIENT ROUTINE SERVICE COST CENTERS	.,,	332/313				
30. 00 03000 ADULTS & PEDIATRICS	-967, 604	2, 633, 857			30.	0. 00
ANCILLARY SERVICE COST CENTERS	101,001					
50. 00 05000 OPERATING ROOM	0	2, 959, 056			50.	0. 00
53. 00 05300 ANESTHESI OLOGY	0	1				3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 556, 509				1. 00
60. 00 06000 LABORATORY	0					0.00
65. 00 06500 RESPIRATORY THERAPY	-77, 072					5. 00
65. 01 06501 CARDI AC REHAB	0				•	5. 01
65. 02 06502 PULMONARY	0	1				5. 02
65. 03 06503 SLEEP STUDY	-41, 490	1				5. 03
66. 00 06600 PHYSI CAL THERAPY	0	2, 516, 728				. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 764	1				. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0					2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0					3. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	310, 278			88.	3. 00
88. 01 08802 RURAL HEALTH CLINIC II	0	2, 833, 512			88.	3. 01
88.02 08801 RURAL HEALTH CLINIC III	0					3. 02
88.03 08803 RURAL HEALTH CLINIC IV	0					3. 03
88.04 08804 RURAL HEALTH CLINIC V	0	1			88.	3. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0				88.	3. 05
90. 00 09000 CLI NI C	0	1				0. 00
90. 01 09001 ORTHOPAEDI C CLI NI C	-3, 510, 362					0. 01
90. 02 09002 SURGI CAL CLI NI C	-744, 320				90.	0. 02
90. 03 09003 CARDI OLOGY CLI NI C	-765, 657	147, 204			90.	0. 03
90. 04 09004 SENI OR CARE CLINI C	0	1			90.	0. 04
90. 05 09005 SPECIALTY CLINIC	0	797, 547				0. 05
91. 00 09100 EMERGENCY	-722, 982					. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	., ,				2. 00
OTHER REIMBURSABLE COST CENTERS		·				
95. 00 09500 AMBULANCE SERVICES	0	2, 185, 406			95.	5. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE	0	0			113.	3. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-9, 819, 453	69, 341, 230			118.	3. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.	0. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o				2. 00
192. 01 19201 OUTREACH	0	269, 383			192.	2. 01
192. 02 19202 CLINIC	0	987, 674			192.	
200.00 TOTAL (SUM OF LINES 118 through 199)	-9, 819, 453				200.	
	•				•	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-1327

Peri od: Worksheet A-0 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am

					5/17/2024 11: 02	2 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	A - RENT		.1			
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	180, 107		1. 00
0.00	EQUI P	0.00				0.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5. 00		0. 00	0	0		5.00
6. 00		0. 00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8. 00		0. 00	0	0		8. 00
9. 00		0. 00	0	0		9. 00
10.00		0. 00	0	0		10.00
11. 00		0. 00	0	0		11.00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14.00
15. 00		0. 00	0	0		15.00
16. 00		0. 00	0	0		16.00
17. 00		0. 00	0	0		17.00
18. 00		0. 00	0	0		18.00
19. 00		0. 00	0	0		19.00
20.00		0. 00	0	0		20.00
21.00		0. 00	0	0		21.00
22.00		0. 00	0	0		22.00
23.00		0. 00	0	0		23.00
24.00			•	0		24.00
	TOTALS		0	180, 107		
	B - CAFE					
1. 00	CAFETERI A	1100	<u>472, 8</u> 53	44 <u>7, 3</u> 07		1. 00
	TOTALS		472, 853	447, 307		
	D - OXYGEN		.1			
	MEDICAL SUPPLIES CHARGED TO	71. 00	0	16, 517		1.00
	PATI ENTS					
2. 00		0. 00	0	0		2. 00
3. 00		0.00	•	0		3.00
	TOTALS		0	16, 517		
4 00	E - UTILITIES	7 00	اه	4/0.004		
1. 00	OPERATION OF PLANT	7. 00	0	169, 334		1.00
2.00		0. 00	0	0		2.00
3. 00		0. 00	0	0		3.00
4. 00		0. 00	0	0		4.00
5. 00		0. 00	0	0		5.00
6. 00		0. 00	0	0		6.00
7. 00		0. 00	0	0		7.00
8. 00		0.00	0_	0		8. 00
	TOTALS		0	169, 334		
4 00	F - I MPLANTS	70.00		2 502 500		4 00
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	3, 503, 508		1. 00
	PATI ENT	+		2 502 500		
	TOTALS		0	3, 503, 508		
	G - LINEN LAUNDRY & LINEN SERVICE	8. 00	6	120 100		1 00
1. 00			0	139, 102		1. 00
	TOTALS H - I NSURANCE		0	139, 102		
1 00	NEW CAP REL COSTS-MVBLE	2 00	ما	241 000		1 00
		2. 00	0	241, 000		1. 00
	TOTALS	+		241, 000		
	I - MEDICAL SUPPLIES		U _I	241,000		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	897, 549		1. 00
	PATIENTS	71.00	٥	097, 349		1.00
2. 00	INTENIS	0. 00	0	0		2.00
3. 00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5. 00		0.00	0	0		5.00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
7. 00 8. 00		0.00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9.00
9. 00 10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
	TOTALS — — — —	<u> </u>	— — — %	00		11.00
	IIUIALO	Į	Ų	697, 549		

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6 From 01/01/2023 Provi der CCN: 14-1327

					To 12/31/2023 Date/Time	
					5/17/2024	11:02 am
	Cost Center	Increases Line #	Sal ary	Other		
	2.00			5. 00		
	J - SPEIR RECLASS	3. 00	4. 00	5.00		
1. 00	RURAL HEALTH CLINIC II	88. 01	1, 439			1, 00
1.00	TOTALS					1.00
	K - KINSOLVING RECLASS		1, 437	U		
1. 00	RURAL HEALTH CLINIC	88. 00	54, 825	0		1.00
1.00	TOTALS		54, 825	— — <u>ö</u>	-	1.00
	L - DEPRECIATION RECLASS B&F		2.7, 2=2	- 1		
1.00	RURAL HEALTH CLINIC II	88. 01	0	25, 445		1.00
2.00	RURAL HEALTH CLINIC IV	88. 03	o	45, 976		2.00
3.00	RURAL HEALTH CLINIC V	88. 04	o	16, 743		3.00
4.00	RURAL HEALTH CLINIC VI	88. 05	o	18, 618		4.00
5.00	ORTHOPAEDIC CLINIC	90. 01	o	196, 695		5. 00
6.00	AMBULANCE SERVICES	95. 00	o	39, 999		6. 00
7.00	OUTREACH	192. 01	o	3, 742		7.00
	TOTALS		0	347, 218		
	M - DEPREICATION RECLASS MME					
1.00	RURAL HEALTH CLINIC	88. 00	0	1, 055		1.00
2.00	RURAL HEALTH CLINIC II	88. 01	0	4, 148		2. 00
3.00	RURAL HEALTH CLINIC IV	88. 03	0	15, 449		3. 00
4.00	RURAL HEALTH CLINIC V	88. 04	0	37, 361		4. 00
5.00	RURAL HEALTH CLINIC VI	88. 05	0	16, 468		5. 00
6.00	CLINIC	90. 00	0	7, 857		6. 00
7.00	ORTHOPAEDIC CLINIC	90. 01	0	29, 010		7.00
8.00	CARDIOLOGY CLINIC	90. 03	0	7, 169		8. 00
9. 00	SENIOR CARE CLINIC	90. 04	0	10, 264		9. 00
10.00	SPECIALTY CLINIC	90. 05	0	84, 120		10.00
11.00	AMBULANCE SERVICES	95. 00	0	58, 443		11.00
12.00	OUTREACH	192. 01	0	4, 887		12.00
13. 00	CLINIC	<u> </u>	•	1 <u>6, 9</u> 41		13. 00
F00 00	TOTALS		500 117	293, 172		F00.65
500.00	Grand Total: Increases	I	529, 117	6, 234, 814		500.00

	Financial Systems	WAI	BASH GENERAL HO				u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der (Peri od: From 01/01/2023	Worksheet A-6
						To 12/31/2023	Date/Time Prepared: 5/17/2024 11:02 am
		Decreases				1	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - RENT	7.00	0.00	7.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	9, 288		l .	1.00
2.00	OPERATION OF PLANT	7. 00	0	48, 716			2.00
3. 00 4. 00	DI ETARY MEDI CAL RECORDS & LI BRARY	10. 00 16. 00	0	14, 600 2, 057			3. 00 4. 00
5. 00	ADULTS & PEDIATRICS	30. 00	o	2, 068	1		5. 00
6.00	OPERATING ROOM	50.00	0	15, 233	1		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 338			7. 00
8. 00 9. 00	LABORATORY RESPI RATORY THERAPY	60. 00 65. 00	0	14, 261 1, 502		0	8. 00 9. 00
10.00	PHYSICAL THERAPY	66. 00	0	11, 502			10.00
11. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	Ö	1, 062			11. 00
	PATI ENTS						
12.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 062			12.00
13. 00 14. 00	RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III	88. 01 88. 02	0	2, 692 1, 833			13. 00 14. 00
15. 00	RURAL HEALTH CLINIC IV	88. 03	o	112			15. 00
16.00	RURAL HEALTH CLINIC V	88. 04	0	3, 050)		16. 00
17. 00	RURAL HEALTH CLINIC VI	88. 05	0	1, 381			17. 00
18. 00 19. 00	CLI NI C ORTHOPAEDI C CLI NI C	90. 00 90. 01	0	1, 466 2, 068			18. 00 19. 00
20.00	SURGI CAL CLINI C	90.01	0	1, 234			20.00
21. 00	SPECIALTY CLINIC	90. 05	O	1, 348		-	21.00
22. 00	EMERGENCY	91. 00	0	2, 068			22. 00
23. 00	AMBULANCE SERVICES	95. 00	0	1, 350		1	23.00
24. 00	OUTREACH	1 <u>92.</u> 01	0	3 <u>8, 8</u> 01 180, 107		<u>)</u>	24. 00
	B - CAFE		<u> </u>	100, 107			
1.00	DI ETARY	1000	472, 853	<u>447, 3</u> 07		D	1.00
	TOTALS		472, 853	447, 307			
1. 00	D - OXYGEN RADI OLOGY-DI AGNOSTI C	54. 00	0	29			1.00
2. 00	RESPIRATORY THERAPY	65. 00	Ö	15, 288			2.00
3.00	AMBULANCE SERVICES	<u>95.</u> 00	0	1, 200		<u>o</u>	3. 00
	TOTALS			16, 517			
1. 00	E - UTILITIES ADMINISTRATIVE & GENERAL	5. 00	0	120, 623	. (1, 00
2. 00	RURAL HEALTH CLINIC II	88. 01	o	1, 200			2.00
3.00	RURAL HEALTH CLINIC III	88. 02	0	6, 000			3. 00
4.00	RURAL HEALTH CLINIC IV	88. 03	0	7, 569			4.00
5. 00 6. 00	RURAL HEALTH CLINIC V RURAL HEALTH CLINIC VI	88. 04 88. 05	0	14, 764 10, 554			5. 00 6. 00
7. 00	SURGI CAL CLINI C	90. 02	0	5, 696		l .	7.00
8.00	OUTREACH	1 <u>92.</u> 01	0	2, 928	B (o l	8. 00
	TOTALS		0	169, 334			
1. 00	F - IMPLANTS OPERATING ROOM	50. 00	ol	3, 503, 508			1.00
1.00	TOTALS		0	3, 503, 508		2	1.00
	G - LINEN						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	139, 102	2	O	1.00
	PATI ENTS	+	— — _o	139, 102	 	-	
	H - I NSURANCE			1077 102			
1. 00	ADMI NI STRATI VE & GENERAL	500	0	241, 000		9	1.00
	TOTALS I - MEDICAL SUPPLIES		0	241, 000)		
1. 00	NONPHYSICIAN ANESTHETISTS	19. 00	0	14, 796			1.00
2. 00	ADULTS & PEDIATRICS	30. 00	Ö	34, 224			2.00
3.00	OPERATING ROOM	50. 00	0	821, 054			3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 097		0	4.00
5. 00 6. 00	LABORATORY RESPI RATORY THERAPY	60. 00 65. 00	0	263 2, 884			5. 00 6. 00
7. 00	PHYSICAL THERAPY	66. 00	0	2, 004 7, 211			7.00
8.00	DRUGS CHARGED TO PATIENTS	73. 00	Ö	2, 319	(8. 00
9. 00	SURGI CAL CLI NI C	90. 02	o	3, 391		l .	9.00
10.00	EMERGENCY	91.00	0	8, 569 741			10.00
11. 00	AMBULANCE SERVICES TOTALS	<u>95.</u> 00	0	<u></u>		<u>)</u>	11.00
	J - SPEIR RECLASS		-1				
1. 00	ORTHOPAEDIC CLINIC	90.01	1, 439	0		D	1. 00
	TOTALS	I	1, 439	O	η		I

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-1327

							5/17/2024 11:02 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	K - KINSOLVING RECLASS						
1.00	RURAL HEALTH CLINIC IV		54, 825	0		<u>D</u>	1.00
	TOTALS		54, 825	C)		
	L - DEPRECIATION RECLASS B&F						
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	347, 218	3	9	1.00
2.00		0.00	0	C)	0	2.00
3.00		0.00	0	C)	0	3.00
4.00		0.00	0	C)	0	4.00
5.00		0.00	0	C)	0	5.00
6.00		0.00	0	C)	0	6.00
7.00		0.00	0	0) (0	7.00
	TOTALS		0	347, 218	3		
	M - DEPREICATION RECLASS MME						
1. 00	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	293, 172	2	9	1.00
2.00		0.00	o	C		o	2.00
3.00		0.00	0	C		o	3.00
4.00		0.00	o	C		o	4.00
5.00		0.00	O	C		o	5.00
6.00		0.00	O	C)	o	6.00
7.00		0.00	O	C)	o	7.00
8.00		0.00	0	C)	o	8.00
9.00		0.00	0	C)	o	9.00
10.00		0.00	0	C)	o	10.00
11.00		0.00	0	C)	o	11.00
12.00		0.00	0	C		O	12.00
13.00		0.00	0	C		O	13.00
	TOTALS			293, 172			
500.00	Grand Total: Decreases		529, 117	6, 234, 814			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Peri od: Worksheet A-7
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Provider CCN: 14-1327

						5/17/2024 11:0	02 am_
				Acquisitions			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	562, 537			410, 215		1.00
2.00	Land Improvements	2, 512, 043			15, 705	0	2.00
3.00	Buildings and Fixtures	44, 996, 206	1, 217, 798	0	1, 217, 798	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fi xed Equi pment	4, 326, 847	46, 364	0	46, 364	0	5.00
6.00	Movable Equipment	15, 113, 526	954, 649	0	954, 649	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	67, 511, 159	2, 644, 731	0	2, 644, 731	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	67, 511, 159	2, 644, 731	0	2, 644, 731	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	972, 752	0				1.00
2.00	Land Improvements	2, 527, 748	0				2.00
3.00	Buildings and Fixtures	46, 214, 004	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	4, 373, 211	0				5.00
6.00	Movable Equipment	16, 068, 175	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	70, 155, 890	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	70, 155, 890	0				10.00
		0 70 155 890	0				

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 14-1327	Peri od: From 01/01/2023	Worksheet A-7

CHAMADY OF CARLEA		02 am			
SUMMARY OF CAPITAL					
·	es (see				
(see instr instructions)	ructions)				
	13. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00 NEW CAP REL COSTS-BLDG & FIXT 1,871,139 0 0 0	0	1.00			
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 2, 516, 365 0 463, 176 0	0	2.00			
3.00 Total (sum of lines 1-2) 4,387,504 0 463,176 0	0	3.00			
SUMMARY OF CAPITAL					
Cost Center Description Other Total (1)					
Capital-Relat (sum of cols.					
ed Costs (see 9 through 14)					
instructions)					
14. 00 15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 1,871,139		1. 00			
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 2, 979, 541		2.00			
3.00 Total (sum of lines 1-2) 0 4,850,680		3.00			

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu	of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 14-1327	Peri od:	Worksheet A-7

nearth Financial Systems was	DASH GENERAL HU	SPITAL DISTRIC	1	III LI E	u of Form CM3-2	2002-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023	Worksheet A-7	
					Part III Date/Time Pre	narod:
				0 12/31/2023	5/17/2024 11:	
	COME	PUTATION OF RAT	TINS	ALLOCATION OF	OTHER CAPITAL	02 dill
	COMI	OTATION OF NA	1103	ALLOCATION OF	OTHER GALLIAE	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	54, 087, 715	0	54, 087, 715	0. 770965	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	16, 068, 175	0	16, 068, 175	0. 229035	0	2.00
3.00 Total (sum of lines 1-2)	70, 155, 890	0	70, 155, 890	1.000000	0	3.00
	ALLOCAT	TION OF OTHER (API TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5	·		
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(1, 523, 921	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(2, 017, 306	180, 107	2.00
3.00 Total (sum of lines 1-2)	o	0	(3, 541, 227	180, 107	3.00
		SL	IMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(0	1, 523, 921	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	463, 176	0	(0	2, 660, 589	2.00
3.00 Total (sum of lines 1-2)	463, 176	0	(0	4, 184, 510	3.00

ADJUSTMENTS TO EXPENSES Provider CCN: 14-1327 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter FLXT 2.00 Investment income - NEW CAP -462, 876 NEW CAP REL COSTS-MVBLE В 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) Refunds and rebates of -4, 769 ADMINISTRATIVE & GENERAL 5.00 В 5.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0 0.00 7.00 stations excluded) (chapter 21) 8.00 Television and radio service 8.00 0.00 0 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physi ci an A-8-2 -6, 829, 487 10.00 adjustment Sale of scrap, waste, etc. 11.00 0 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 0 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -239. 349 CAFETERI A 14 00 В 11 00 O 14 00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical -1, 764 MEDICAL SUPPLIES CHARGED TO 16.00 71.00 16.00 supplies to other than PATI ENTS pati ents Sale of drugs to other than 17.00 0.00 17.00 pati ents 18.00 Sale of medical records and -13, 028 MEDI CAL RECORDS & LI BRARY 18.00 В 16.00 abstracts 19.00 Nursing and allied health 19.00 0.00 0 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 24.00 66.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 Utilization review -114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT
Depreciation - NEW CAP REL IFI XT ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Physicians' assistant 29.00 29.00 0.00 Adjustment for occupational A-8-3 0 *** Cost Center Deleted *** 30.00 30.00 67.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Heal th	Financial Systems	WAE	BASH GENERAL HO	SPITAL DISTRICT	In Lie	eu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 01/01/2023	Data (Time Data		
					To 12/31/2023	Date/Time Pre 5/17/2024 11:		
				Expense Classification or	n Worksheet A	37 177 2024 11.	OZ alli	
				To/From Which the Amount is				
				To the file file file of the	to be haj astea			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
	·	(2)				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	DI ETARY	В	-15, 404	DI ETARY	10.00	0	33.00	
33. 01	PHYSICIAN RECRUITMENT	A	-193, 681	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01	
33. 02	LOBBYING DUES	A	-17, 776	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02	
00 00	00014 041 451/		4 070 070	NONELLICOLOU AND AND ATTECT OF O	40.00			

-9, 819, 453

-202, 452 EMPLOYEE BENEFITS DEPARTMENT

-1, 373, 373 NONPHYSICIAN ANESTHETISTS

15, 989 NEW CAP REL COSTS-MVBLE
EQUI P
-481, 483 ADMI NI STRATI VE & GENERAL

4.00

2.00

5.00

19.00

33.03

33.04

33.05

33.06

50.00

Α

Α

Α

CRNA EMP BEN

BOND INSURANCE

33.06 NON ALLLOWABLE MARKETING

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

33. 03 CRNA SALARY

33.04

33.05

column 6, line 200.) (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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 14-1327

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

						10 12/31/2023	3 Date/IIMe Pro 5/17/2024 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	967, 604	967, 60	04	0	0	1.00
2. 00	65. 00	RESPI RATORY THERAPY	77, 072	77, 07	72 C	0	0	2.00
3.00	65. 03	SLEEP STUDY	41, 490	41, 49	90	0	0	3.00
4.00	90. 01	ORTHOPAEDIC CLINIC	3, 522, 657	3, 510, 36	12, 295	0	0	4.00
5. 00	90. 02	SURGICAL CLINIC	770, 458	744, 32	26, 138	0	0	5. 00
6.00	90. 03	CARDIOLOGY CLINIC	805, 954	765, 65	57 40, 297	0	0	6. 00
7. 00	91. 00	EMERGENCY	2, 301, 130	722, 98	1, 578, 148	0	0	7. 00
8. 00	0. 00		0		0	0	0	8. 00
9. 00	0.00		0		0 0	0	0	9. 00
10.00	0.00		0		0 0	0	0	10.00
200.00			8, 486, 365	6, 829, 48	1, 656, 878		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	f Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t	Unadjusted RO	CE Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0		0 0	1	-	1
2. 00		RESPI RATORY THERAPY	0		0	0		
3. 00		SLEEP STUDY	0		0	0	0	0.00
4. 00		ORTHOPAEDIC CLINIC	0		0	0	0	
5. 00		SURGICAL CLINIC	0		0	0	0	0.00
6.00		CARDIOLOGY CLINIC	0		0	0	0	0.00
7. 00		EMERGENCY	0		0	0	0	7. 00
8. 00	0. 00		0		0	0	0	0.00
9. 00	0. 00		0		0	0	0	7.00
10. 00	0. 00		0		0	0	0	
200.00			0		0 0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	15.00		0 0			1. 00
2. 00		RESPIRATORY THERAPY	0					2.00
3. 00		SLEEP STUDY	0			41, 490		3.00
4. 00		ORTHOPAEDIC CLINIC				3, 510, 362		4.00
5. 00		SURGICAL CLINIC	0			744, 320	1	5.00
6. 00		CARDIOLOGY CLINIC	1			765, 657		6.00
7. 00		EMERGENCY				705, 057		7.00
8. 00	0.00		1			122, 702		8.00
9. 00	0.00		1					9.00
10. 00	0.00		0					10.00
200.00	0.00					6, 829, 487		200.00
200.00	1		1	I		0,027,407	I	200.00

Provider CCN: 14-1327

Peri od:

From 01/01/2023

COST ALLOCATION - GENERAL SERVICE COSTS

Part I

Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am CAPITAL RELATED COSTS Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal Cost Center Description for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1, 523, 921 1, 523, 921 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2, 660, 589 2, 660, 589 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 454, 856 4.00 1, 453, 481 1.375 4.00 00500 ADMINISTRATIVE & GENERAL 1, 630, 915 5.00 257, 600 150, 569 10, 305, 166 12, 344, 250 5.00 7.00 00700 OPERATION OF PLANT 2, 478, 543 35, 542 32, 596 15, 223 2, 561, 904 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 139, 102 17, 716 156, 818 8.00 881, 867 00900 HOUSEKEEPI NG 820, 850 9.00 9 00 17,716 21 619 21 682 237, 375 10.00 01000 DI ETARY 141, 402 70, 672 22, 016 3, 285 10.00 11.00 01100 CAFETERI A 680, 811 17, 083 0 19, 278 717, 172 11.00 13.00 01300 NURSING ADMINISTRATION 738, 884 5, 502 0 24, 933 769, 319 13.00 01600 MEDICAL RECORDS & LIBRARY 16 00 1 624 305 617 20 321 1, 645, 243 16 00 17.00 01700 SOCIAL SERVICE 273, 610 3,851 374 8, 386 286, 221 17.00 01900 NONPHYSICIAN ANESTHETISTS 55, 991 19.00 19.00 306, 343 362, 334 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 633, 857 82, 851 30.00 332, 759 75, 650 3, 125, 117 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 959, 056 315, 790 3, 662, 736 50.00 326, 786 61, 104 05300 ANESTHESI OLOGY 54, 037 53 00 54, 037 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 556, 509 90,039 254, 631 44,045 2, 945, 224 54.00 3, 096, 674 3, 311, 267 06000 LABORATORY 111, 922 47, 982 60.00 54,689 60.00 65.00 06500 RESPIRATORY THERAPY 638, 807 22, 723 55, 694 22, 305 739, 529 65.00 06501 CARDLAC REHAB 207.608 6, 291 235, 714 65.01 21, 815 0 65 01 65.02 06502 PULMONARY 209, 235 3, 193 212, 428 65.02 \cap 06503 SLEEP STUDY 328, 255 2,076 65.03 22,778 10,540 363, 649 65.03 06600 PHYSI CAL THERAPY 71,030 2, 601, 359 66.00 2, 516, 728 13.601 66,00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 394, 315 71.00 1, 322, 887 52.378 7.837 11, 213 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 3, 503, 508 3, 503, 508 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 795 73.00 6, 432, 597 29,820 21, 720 6, 488, 932 73 00 OUTPATIENT SERVICE COST CENTERS 88 00 88.00 08800 RURAL HEALTH CLINIC 310, 278 63, 382 0 6.518 380, 178 08802 RURAL HEALTH CLINIC II 2, 833, 512 0 95, 726 2, 929, 238 88.01 88.01 08801 RURAL HEALTH CLINIC III 88.02 1, 228, 364 C 0 41,009 1, 269, 373 88 02 08803 RURAL HEALTH CLINIC IV 88.03 1.371.301 0 42.431 1, 413, 732 C 88.03 08804 RURAL HEALTH CLINIC V 0 88.04 1, 100, 345 Ω 29, 274 1, 129, 619 88.04 88.05 08805 RURAL HEALTH CLINIC VI 873.345 0 0 23, 418 896, 763 88.05 90.00 09000 CLI NI C 1, 187, 690 0 25, 232 1, 212, 922 0 90.00 09001 ORTHOPAEDIC CLINIC 90 01 3, 387, 282 0 229, 301 90 01 0 3, 616, 583 90.02 09002 SURGI CAL CLINIC 715, 699 C 0 38, 193 753, 892 90.02 90.03 09003 CARDIOLOGY CLINIC 147, 204 0 33, 712 180, 916 90.03 09004 SENIOR CARE CLINIC 0 6, 488 326, 804 90.04 90.04 320, 316 C 09005 SPECIALTY CLINIC 90.05 797.547 0 6, 365 803, 912 90.05 91.00 09100 EMERGENCY 3, 330, 213 73,093 56, 419 75, 326 3, 535, 051 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 185, 406 0 0 60, 276 2, 245, 682 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 69, 341, 230 1, 517, 319 2, 660, 589 1, 415, 211 69, 294, 983 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6, 602 6, 602 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192 00 0 C 0 192. 01 19201 OUTREACH 269, 383 C 0 8,744 278, 127 192. 01 192. 02 19202 CLI NI C 987, 674 0 30, 901 1, 018, 575 192. 02 C 200.00 Cross Foot Adjustments 0 200. 00 201 00 Negative Cost Centers 0 201 00 202.00 TOTAL (sum lines 118 through 201) 70, 598, 287 1, 523, 921 2, 660, 589 1, 454, 856 70, 598, 287 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 5/17/2024 11:02 am

						5/17/2024 11:	02 am
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	12, 344, 250					5.00
7. 00	00700 OPERATION OF PLANT	542, 878	3, 104, 782				7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	33, 230	44, 741				8.00
9. 00	00900 HOUSEKEEPI NG	186, 871	44, 741	8, 874	l		9.00
10. 00	01000 DI ETARY	50, 301	178, 478			534, 221	1
11. 00	01100 CAFETERI A	151, 972	43, 143		16, 059	0	1
13. 00	01300 NURSING ADMINISTRATION	1				0	1
16. 00		163, 022	13, 895	1	5, 172	0	
	01600 MEDICAL RECORDS & LIBRARY	348, 634	0	0	0 (00		
17. 00	01700 SOCI AL SERVI CE	60, 651	9, 726	1	3, 620	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	76, 780	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			T			
30. 00	03000 ADULTS & PEDIATRICS	662, 225	840, 353	88, 500	312, 795	534, 221	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	776, 148	825, 279	42, 313	307, 185	0	1
53.00	05300 ANESTHESI OLOGY	11, 451	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	624, 105	227, 388	23, 943	84, 638	0	54.00
60.00	06000 LABORATORY	701, 671	138, 114	1, 291	51, 409	0	60.00
65.00	06500 RESPIRATORY THERAPY	156, 709	57, 385	1, 013	21, 360	0	65.00
65. 01	06501 CARDI AC REHAB	49, 949	55, 093	0	20, 507	0	65. 01
65. 02	06502 PULMONARY	45, 014	0	0	o	0	65. 02
65. 03	06503 SLEEP STUDY	77, 059	57, 524	4, 135	21, 412	0	65. 03
66.00	06600 PHYSI CAL THERAPY	551, 238	. 0	16, 670		0	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	295, 461	132, 278		49, 236	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	742, 407	0.02,270	Ö	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 375, 018	75, 310		28, 032	0	
70.00	OUTPATIENT SERVICE COST CENTERS	1,070,010	70,010	L	20,002		70.00
88. 00	08800 RURAL HEALTH CLINIC	80, 561	160, 068	0	59, 580	0	88. 00
88. 01	08802 RURAL HEALTH CLINIC II	620, 717	00,000	1		Ö	
88. 02	08801 RURAL HEALTH CLINIC III	268, 985	0	1		0	
88. 03	08803 RURAL HEALTH CLINIC IV	299, 575	0	0 1,030	0	0	
88. 04	08804 RURAL HEALTH CLINIC V	1	0	0	0	0	1
		239, 371	0	0	U	0	1
88. 05	08805 RURAL HEALTH CLINIC VI	190, 028	0	2 000	U		
90.00	09000 CLINIC	257, 023	0	3, 988	0	0	
90. 01	09001 ORTHOPAEDI C CLI NI C	766, 368	0	0	0	0	
90. 02	09002 SURGI CAL CLI NI C	159, 753	0	0	0	0	
90. 03	09003 CARDI OLOGY CLI NI C	38, 337	0	0	0	0	
90. 04	09004 SENI OR CARE CLINI C	69, 251	0	0	0	0	
90. 05	09005 SPECIALTY CLINIC	170, 352	0	0	0	0	
91.00	09100 EMERGENCY	749, 091	184, 592	40, 744	68, 709	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	475, 869	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS			•			
113.0	11300 I NTEREST EXPENSE						113.00
118.0	SUBTOTALS (SUM OF LINES 1 through 117)	12, 068, 075	3, 088, 108	234, 789	1, 116, 147	534, 221	
	NONREI MBURSABLE COST CENTERS	,	.,,				
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 399	16, 674	0	6, 206	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 377	10, 074		0, 200		192.00
	1 19201 OUTREACH	58, 936	0	0	0		192.00
	2 19202 CLINI C	215, 840	0				192.01
		213, 640	U			U	
200. 0			^	_		^	200.00
201. 0		12 244 252	2 104 700	004 700	1 100 050		201.00
202. 0	TOTAL (sum lines 118 through 201)	12, 344, 250	3, 104, 782	234, 789	1, 122, 353	534, 221	1202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1327

				To	12/31/2023	Date/Time Pre 5/17/2024 11:	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL	NONPHYSI CI AN	UZ alli
	, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI O	RECORDS &	SERVI CE	ANESTHETI STS	
			N	LI BRARY			
		11. 00	13. 00	16. 00	17. 00	19. 00	
1 00	GENERAL SERVICE COST CENTERS		I	ı			4 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
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	928, 346					11.00
13.00	01300 NURSING ADMINISTRATION	0	951, 408				13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 993, 877			16. 00
17. 00	01700 SOCI AL SERVI CE	13, 171	0	-	373, 389		17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0]	439, 114	19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 415	404 107	1 224 274	272 200	0	20.00
30. 00	03000 ADULTS & PEDIATRICS	192, 415	404, 137	1, 324, 374	373, 389	0	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	151, 079	317, 316	98, 779	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	131, 0/9	317, 310	1	0	439, 114	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	107, 845	0	29, 268	0	0	1
60.00	06000 LABORATORY	103, 098	0	32, 926	0	0	1
65.00	06500 RESPIRATORY THERAPY	40, 149	0	7, 317	0	0	65.00
65. 01	06501 CARDI AC REHAB	11, 576	О	0	0	0	65. 01
65.02	06502 PULMONARY	6, 946	0	0	0	0	65.02
65. 03	06503 SLEEP STUDY	13, 933	0	0	0	0	65. 03
66.00	06600 PHYSI CAL THERAPY	0	0	36, 585	0	0	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 670		0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	- 1	0	0	72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	25, 537	0	0	0	0	73.00
88. 00	08800 RURAL HEALTH CLINIC	8, 152	0	0	0	0	88. 00
88. 01	08802 RURAL HEALTH CLINIC II	0, 132	0	40, 243	ő	0	88. 01
88. 02	08801 RURAL HEALTH CLINIC III	41, 051	l o	65, 853	Ö	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	51, 219	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88. 05
90.00	09000 CLI NI C	43, 670	0	32, 926	0	0	90.00
90. 01	09001 ORTHOPAEDIC CLINIC	0	0	274, 387	0	0	90. 01
90. 02	09002 SURGI CAL CLI NI C	0	0	0	0	0	90.02
90.03	09003 CARDI OLOGY CLINI C	18, 910	0	0	0	0	90.03
90. 04 90. 05	09004 SENI OR CARE CLI NI C	15 (50	0	0	0	0	90.04
90.05	09005 SPECIALTY CLINIC 09100 EMERGENCY	15, 659 109, 485		0	0	0	90. 05 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 465	227, 733		U	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS				- 1		
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	928, 346	951, 408	1, 993, 877	373, 389	439, 114	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	1	0		192.00
	19201 OUTREACH	0	0		0		192. 01
192. 0 ₂ 200. 00	19202 CLINIC		0	0	0		192. 02 200. 00
200.00		_		0	0	0	200.00
201.00		928, 346	951, 408	1, 993, 877	373, 389		
202.00	1.0 (3 1.1.35 110 till 34gil 201)	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	370,007	107, 114	,_02.00

Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part VI mo Propagation Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1327

					To 12/31/2023		Prepared:
	Cost Center Description	Subtotal	Intern &	Total		3/11/2024	1.02 alli
	·		Resi dents				
			Cost & Post				
			Stepdown Adjustments				
		24. 00	25. 00	26. 00			
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCI AL SERVI CE						17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS						19. 00
30 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	7, 857, 526	0	7, 857, 52	5		30.00
00.00	ANCILLARY SERVICE COST CENTERS	7,007,020	3	7,007,02			00.00
50. 00		6, 180, 835	0	6, 180, 83			50.00
53.00	05300 ANESTHESI OLOGY	504, 602	0	504, 60			53.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	4, 042, 411 4, 339, 776	0	4, 042, 41 4, 339, 77			54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	1, 023, 462	0	1, 023, 46			65.00
65. 01	06501 CARDI AC REHAB	372, 839	0	372, 83			65. 01
65. 02	06502 PULMONARY	264, 388	0	264, 38			65. 02
65. 03	06503 SLEEP STUDY	537, 712	0	537, 71			65. 03
66. 00 71. 00	06600 PHYSICAL THERAPY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 205, 852 1, 896, 960	0	3, 205, 85: 1, 896, 96			66. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	4, 245, 915	0	4, 245, 91			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 992, 829	0	7, 992, 82			73.00
	OUTPATIENT SERVICE COST CENTERS				_1		
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08802 RURAL HEALTH CLINIC II	688, 539 3, 590, 852	0	688, 53 ¹ 3, 590, 85			88. 00 88. 01
88. 02	08801 RURAL HEALTH CLINIC III	1, 646, 292	0	1, 646, 29			88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 764, 526	Ö	1, 764, 52			88. 03
88. 04	08804 RURAL HEALTH CLINIC V	1, 368, 990	0	1, 368, 99	O		88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	1, 086, 791	0	1, 086, 79			88. 05
90. 00 90. 01	09000 CLI NI C 09001 ORTHOPAEDI C CLI NI C	1, 550, 529 4, 657, 338	0	1, 550, 52 ⁹ 4, 657, 33 ⁹			90. 00 90. 01
90. 01	09002 SURGI CAL CLI NI C	913, 645	0	913, 64			90.01
90. 03	09003 CARDI OLOGY CLI NI C	238, 163	0	238, 16			90.03
90. 04	09004 SENIOR CARE CLINIC	396, 055	0	396, 05			90. 04
90.05	09005 SPECIALTY CLINIC	989, 923	0	989, 92			90.05
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 917, 627	0	4, 917, 62	/		91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS		0				72.00
95. 00	09500 AMBULANCE SERVI CES	2, 721, 551	0	2, 721, 55	1		95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						112 00
113.00		68, 995, 928	0	68, 995, 92	8		113. 00 118. 00
	NONREI MBURSABLE COST CENTERS	33, 7, 73, 720	<u> </u>	33, 7,0, 72	-1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 881	0	30, 88			190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0)		192.00
	19201 OUTREACH 19202 CLI NI C	337, 063 1, 234, 415	0	337, 06 1, 234, 41			192. 01 192. 02
200. 00		1, 234, 415	0				200.00
201.00	Negative Cost Centers	o	o				201.00
202.00	TOTAL (sum lines 118 through 201)	70, 598, 287	О	70, 598, 28	7		202. 00

113.00

0 190.00

0 192.00

8 192.01

30 192.02

0 201.00

1, 375 202. 00

200.00

1, 337 118, 00

Health Financial Systems WABASH GENERAL HOSPITAL DISTRICT In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1327 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Di rectly NEW BLDG & NEW MVBLE Subtotal Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 4.00 2A GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 375 1, 375 1, 375 4.00 0 00500 ADMINISTRATIVE & GENERAL 1, 630, 915 1, 888, 515 257, 600 5.00 144 5.00 00700 OPERATION OF PLANT 15 7.00 35, 542 32, 596 68, 138 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0000000 17, 716 17, 716 0 8.00 9.00 00900 HOUSEKEEPI NG 17, 716 21, 619 39, 335 21 9.00 92, 688 10.00 01000 DI ETARY 70, 672 10.00 22,016 3 11.00 01100 CAFETERI A 17,083 0 17,083 18 11.00 13.00 01300 NURSING ADMINISTRATION 5, 502 0 5,502 24 13.00 01600 MEDICAL RECORDS & LIBRARY 19 16.00 16.00 C 617 617 01700 SOCIAL SERVICE 17.00 17 00 3, 851 374 4, 225 8 01900 NONPHYSICIAN ANESTHETISTS 19.00 54 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 75, 650 0 79 30.00 30.00 332, 759 408, 409 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 326, 786 315, 790 642, 576 58 50.00 05300 ANESTHESI OLOGY 53.00 54, 037 54,037 0 53.00 00000000 05400 RADI OLOGY-DI AGNOSTI C 90.039 54 00 254, 631 344, 670 42 54 00 06000 LABORATORY 60.00 54, 689 111, 922 166, 611 46 60.00 06500 RESPIRATORY THERAPY 22, 723 55, 694 78, 417 21 65.00 65.00 21, 815 21, 815 65.01 06501 CARDI AC REHAB 0 65.01 6 06502 PULMONARY 65.02 65.02 0 3 65.03 06503 SLEEP STUDY 22, 778 2,076 24, 854 10 65.03 06600 PHYSI CAL THERAPY 66.00 13,601 13,601 68 66.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 52, 378 7,837 60, 215 11 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 72.00 0 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 0 29, 820 4, 795 34, 615 21 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 63.382 63, 382 6 0 88.01 08802 RURAL HEALTH CLINIC II 0 92 88.01 08801 RURAL HEALTH CLINIC III 0 0 39 88.02 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV 00000000 0 0 0 41 88. 03 0 88.04 08804 RURAL HEALTH CLINIC V 0 88 04 C 28 88.05 08805 RURAL HEALTH CLINIC VI 0 22 88.05 90 00 09000 CLI NI C 0 0 0 24 90 00 09001 ORTHOPAEDIC CLINIC 0 90.01 0 203 90.01 0 09002 SURGICAL CLINIC 0 0 90.02 C 37 90 02 90.03 09003 CARDIOLOGY CLINIC 0 0 32 90.03 90.04 09004 SENIOR CARE CLINIC 0 o 90.04 6 09005 SPECIALTY CLINIC 0 90.05 90.05 0 0 6 91.00 09100 EMERGENCY 73,093 56, 419 129, 512 72 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 0 0 0 58 95.00

0

0

0

0

0

0

1, 517, 319

1, 523, 921

6,602

C

C

2, 660, 589

2, 660, 589

0

0

0

0

4, 177, 908

4, 184, 510

6,602

0

0

0

0

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

113. 00 11300 I NTEREST EXPENSE

192. 01 19201 OUTREACH

192. 02 19202 CLI NI C

118.00

200.00

201.00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 1 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1327

				To	o 12/31/2023	Date/Time Pre 5/17/2024 11:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	02 0111
	•	E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 888, 659					5.00
7.00	00700 OPERATION OF PLANT	83, 059	151, 212				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 084	2, 179	24, 979			8. 00
9. 00	00900 HOUSEKEEPI NG	28, 591	2, 179		71, 070		9. 00
10. 00	01000 DI ETARY	7, 696			4, 207	113, 460	10.00
11. 00	01100 CAFETERI A	23, 251	2, 101	0	1, 017	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	24, 942	677	0	327	0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	53, 340	0		0	_	16.00
17. 00	01700 SOCIAL SERVICE	9, 280	474	-	229	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	11, 747	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	101.010			10.00/		
30. 00	03000 ADULTS & PEDIATRICS	101, 319	40, 928	9, 414	19, 806	113, 460	30.00
FO 00	ANCI LLARY SERVI CE COST CENTERS	110 750	40, 102	4 500	10. 450	0	
50.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	118, 750	40, 193 0		19, 452 0	0	50.00 53.00
53. 00 54. 00		1, 752		_	-	0	ł
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	95, 487	11, 074		5, 359	0	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	107, 355 23, 976	6, 727 2, 795		3, 255	0	65.00
65. 00	06501 CARDI AC REHAB				1, 353		65.00
65. 02	06502 PULMONARY	7, 642 6, 887	2, 683 0		1, 299 0		65.01
65. 03	06503 SLEEP STUDY	11, 790	2, 802		1, 356	-	65.03
66. 00	06600 PHYSI CAL THERAPY	84, 339	2,802		1, 330	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45, 205	6, 442		3, 118		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	113, 587	0, 442		3, 110		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	210, 385	3, 668	-	1, 775		73.00
70.00	OUTPATIENT SERVICE COST CENTERS	210,000	0,000	<u> </u>	1,770		70.00
88. 00	08800 RURAL HEALTH CLINIC	12, 326	7, 796	0	3, 773	0	88. 00
88. 01	08802 RURAL HEALTH CLINIC II	94, 969			. 0		88. 01
88. 02	08801 RURAL HEALTH CLINIC III	41, 154	0	110	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	45, 835	0	0	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	36, 623	0	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	29, 074	0	0	0	0	88. 05
90.00	09000 CLI NI C	39, 324	0	424	0	0	90.00
90. 01	09001 ORTHOPAEDIC CLINIC	117, 253	0	0	0	0	90. 01
90.02	09002 SURGI CAL CLINI C	24, 442	0	0	0	0	90. 02
90. 03	09003 CARDI OLOGY CLI NI C	5, 865	0	0	0	0	90. 03
90.04	09004 SENIOR CARE CLINIC	10, 595	0	0	0	0	90. 04
90. 05	09005 SPECIALTY CLINIC	26, 064	0	0	0	0	90. 05
91.00	09100 EMERGENCY	114, 610	8, 990	4, 335	4, 351	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	72, 807	0	0	0	0	95.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	1 044 405	150 400	24 070	70 /77		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 846, 405	150, 400	24, 979	70, 677	113, 460	1118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	812	O	393	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	012		0		192.00
	19200 PHISICIANS PRIVATE OFFICES	9, 017		0	0		192.00
	2 19202 CLINI C	33, 023	0	0	0		192.01
200.00	Cross Foot Adjustments	33, 323			O		200.00
200.00		0	n	n	n		201.00
202.00		1, 888, 659	151, 212	24, 979	71, 070		
	1	.,,,		= ., ., .,	, 0, 0	1 ,	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1327

				10	12/31/2023	5/17/2024 11:	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	NONPHYSI CI AN	OZ GIII
	, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI O	RECORDS &	SERVI CE	ANESTHETI STS	
			N	LI BRARY			
		11. 00	13. 00	16.00	17. 00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	43, 470					11.00
13.00	01300 NURSING ADMINISTRATION	0	31, 472				13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		4.4 000		16.00
17.00	01700 SOCIAL SERVICE	617	0		14, 833		17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	11, 801	19.00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.010	40.040	25 252	4.4.000		00.00
30. 00	03000 ADULTS & PEDI ATRI CS	9, 010	13, 368	35, 853	14, 833		30.00
EO 00	ANCILLARY SERVICE COST CENTERS	7.074	10 407	2 (74	0		FO 00
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	7, 074 0	10, 497	2, 674	0		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 050	0	-	0		53. 00 54. 00
60.00	06000 LABORATORY	4, 828	0	891	0		60.00
65. 00	06500 RESPIRATORY THERAPY	4, 828 1, 880	0	198	0		65.00
65. 01	06501 CARDI AC REHAB	542	0	190	0		65. 00
65. 02	06502 PULMONARY	325	0		0		65. 02
65. 03	06503 SLEEP STUDY	652	0		0		65.03
66. 00	06600 PHYSI CAL THERAPY	032	0	990	0		66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 202	0	7,0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 202	0	-	0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 196			0		73.00
70.00	OUTPATIENT SERVICE COST CENTERS	., ., .		5	<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	382	0	0	0		88. 00
88. 01	08802 RURAL HEALTH CLINIC II	0	0		0		88. 01
88. 02	08801 RURAL HEALTH CLINIC III	1, 922	0	1, 783	0		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	1, 387	0		88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	0	0		88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	0	0		88. 05
90.00	09000 CLI NI C	2, 045	0	891	0		90.00
90. 01	09001 ORTHOPAEDI C CLI NI C	0	0	7, 428	0		90. 01
90. 02	09002 SURGI CAL CLI NI C	0	0	0	0		90. 02
90. 03	09003 CARDI OLOGY CLI NI C	885	0	0	0		90. 03
90. 04	09004 SENI OR CARE CLI NI C	0	0	0	0		90. 04
90. 05	09005 SPECIALTY CLINIC	733	0	0	0		90. 05
91. 00	09100 EMERGENCY	5, 127	7, 607	0	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS		_		_		
95.00	09500 AMBULANCE SERVI CES	0	0	0	0		95.00
440.00	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	40 470	04 470	F0 07/	44.000		113.00
118.00	3 7	43, 470	31, 472	53, 976	14, 833	0	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0			0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	-	0		192.00
	19201 OUTREACH	0	0	0	0		192. 01 192. 02
200.00	19202 CLINIC Cross Foot Adjustments	0	١		U	11, 801	
200.00		^	_		0		200.00
201.00		43, 470	31, 472	53, 976	14, 833		202.00
202.00	TOTAL (Sum Times 110 till ough 201)	43, 470	31,472	33, 770	14, 033	11,001	1202.00

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1327

					To 12/31/2023	
	Cost Center Description	Subtotal	Intern &	Total		5/17/2024 11:02 am
	cost center bescriptron	Subtotal	Resi dents	Total		
			Cost & Post			
			Stepdown			
		24.00	Adjustments	24 00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
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
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	766, 479	0	766, 4	79	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.45 77.1		0.45 7	7.	50.00
50. 00 53. 00	O5000 OPERATI NG ROOM O5300 ANESTHESI OLOGY	845, 776 55, 789	0			50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	465, 021	0			54.00
60.00	06000 LABORATORY	289, 850	0			60.00
65.00	06500 RESPI RATORY THERAPY	108, 748	0			65. 00
65. 01	06501 CARDI AC REHAB	33, 987	0			65. 01
65. 02	06502 PULMONARY	7, 215	0	.,-		65. 02
65. 03 66. 00	06503 SLEEP STUDY 06600 PHYSI CAL THERAPY	41, 904 100, 772	0	41, 90 100, 7		65. 03 66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 193	0			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	113, 587	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	251, 660	0	251, 66	60	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	07.445		I 07.4	/ E	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08802 RURAL HEALTH CLINIC II	87, 665 96, 220	0			88. 00 88. 01
88. 02	08801 RURAL HEALTH CLINIC III	45, 008	0			88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	47, 263	0			88. 03
88. 04	08804 RURAL HEALTH CLINIC V	36, 651	0	36, 65	51	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	29, 096	0			88. 05
90.00	09000 CLI NI C 09001 ORTHOPAEDI C CLI NI C	42, 708	0	,		90.00
90. 01 90. 02	09001 ORTHOPAEDI C CEINI C	124, 884 24, 479	0			90. 01
90. 03	09003 CARDI OLOGY CLI NI C	6, 782	0			90. 03
90. 04	09004 SENIOR CARE CLINIC	10, 601	0			90.04
90. 05	09005 SPECIALTY CLINIC	26, 803	0	,		90. 05
91.00	09100 EMERGENCY	274, 604	0		04	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0			92.00
95. 00	09500 AMBULANCE SERVICES	72, 865	0	72, 80	65	95.00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE		_			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 122, 610	0	4, 122, 6	10	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 021	0	8, 02	21	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0,021	0		0	192.00
192. 01	19201 OUTREACH	9, 025	0			192. 01
	19202 CLI NI C	33, 053	0			192. 02
200.00		11, 801	0	,		200.00
201. 00 202. 00		0 4, 184, 510	0	•	0	201. 00 202. 00
202.00	TOTAL (Sum TITIES TTO EMOUGH 201)	7, 104, 510	0	1 7, 104, 5		1202.00

Provider CCN: 14-1327

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				-	Γο 12/31/2023	Date/Time Pre 5/17/2024 11:	
		CAPI TAL REI	ATED COSTS			37 177 2024 11.	UZ alli
	Coot Contor Decement on	NEW BLDG &	NEW MVBLE	EMDLOVEE	Doggood Lightin	ADMI NI STRATI V	
	Cost Center Description	FIXT	EQUIP	EMPLOYEE BENEFITS	n	E & GENERAL	
		(SQUARE	(DEPRECIATION	DEPARTMENT		(ACCUM.	
		FEET))	(GROSS		COST)	
		1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
GENE	RAL SERVICE COST CENTERS				-		
	O NEW CAP REL COSTS-BLDG & FIXT	55, 396					1.00
	O NEW CAP REL COSTS-MVBLE EQUIP O EMPLOYEE BENEFITS DEPARTMENT	50	2, 222, 444	35, 685, 67 ⁻	7		2. 00 4. 00
	O ADMINISTRATIVE & GENERAL	9, 364				58, 254, 037	5.00
	O OPERATION OF PLANT	1, 292				2, 561, 904	7. 00
	O LAUNDRY & LINEN SERVICE	644		504.04	-	156, 818	
	O HOUSEKEEPI NG O DI ETARY	644 2, 569				881, 867 237, 375	9. 00 10. 00
	O CAFETERI A	621	0	472, 85		717, 172	11.00
	O NURSING ADMINISTRATION	200				769, 319	
	O MEDICAL RECORDS & LIBRARY O SOCIAL SERVICE	0 140				1, 645, 243	1
	O NONPHYSICIAN ANESTHETISTS	140					
	TIENT ROUTINE SERVICE COST CENTERS	_		.,,	-		
	O ADULTS & PEDI ATRI CS	12, 096	63, 192	2, 032, 20	5 0	3, 125, 117	30.00
	LLARY SERVICE COST CENTERS O OPERATING ROOM	11, 879	263, 786	1, 498, 77	9 0	3, 662, 736	50.00
	O ANESTHESI OLOGY	0					1
	O RADI OLOGY-DI AGNOSTI C	3, 273				2, 945, 224	
	O LABORATORY	1, 988		1, 176, 93		3, 311, 267	
	O RESPI RATORY THERAPY 1 CARDI AC REHAB	826 793		547, 100 154, 30°		739, 529 235, 714	
	2 PULMONARY	0		78, 31		212, 428	
	3 SLEEP STUDY	828				363, 649	
	O PHYSICAL THERAPY O MEDICAL SUPPLIES CHARGED TO PATIENTS	0 1, 904	,	1, 742, 25		2, 601, 359	
	O IMPL. DEV. CHARGED TO PATIENTS	1, 904	6, 546 0	275, 03		1, 394, 315 3, 503, 508	
	O DRUGS CHARGED TO PATIENTS	1, 084	4, 005	532, 75	3 0		
OUTP	ATLENT SERVICE COST CENTERS	0.004	1 0	450.00		200 470	00.00
	O RURAL HEALTH CLINIC 2 RURAL HEALTH CLINIC II	2, 304 0		,			
	1 RURAL HEALTH CLINIC III	Ö				1, 269, 373	
	3 RURAL HEALTH CLINIC IV	0	1			.,,	1
	4 RURAL HEALTH CLINIC V 5 RURAL HEALTH CLINIC VI	0	0	718, 05 ⁻ 574, 41 ⁻		1, 129, 619 896, 763	
	O CLINIC	0	0	618, 900		1, 212, 922	1
	1 ORTHOPAEDIC CLINIC	0	0	5, 624, 73	1 0	3, 616, 583	90. 01
	2 SURGLCAL CLINIC 3 CARDLOLOGY CLINIC	0	0	936, 80		753, 892	
	4 SENIOR CARE CLINIC		0	826, 91: 159, 14		180, 916 326, 804	
90. 05 0900	5 SPECIALTY CLINIC	Ö				803, 912	90.05
	O EMERGENCY	2, 657	47, 128	1, 847, 629	9 0	3, 535, 051	
	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS						92.00
	O AMBULANCE SERVICES	0	0	1, 478, 48	3 0	2, 245, 682	95. 00
	I AL PURPOSE COST CENTERS	l	I	1		ı	
113.00 1130	O INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	55, 156	2, 222, 444	34, 713, 250	-12, 344, 250	56, 950, 733	113.00
	EI MBURSABLE COST CENTERS	33, 130	2,222, 444	34,713,23	72, 344, 230	30, 730, 733	1110.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	240		1	0		190. 00
192. 00 1920 192. 01 1920	O PHYSICIANS' PRIVATE OFFICES	0	1	1	0		192.00
192. 02 1920		0	-	757, 94			
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	1 500 001	2 //0 500	1 454 05	,	10 044 050	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 523, 921	2, 660, 589	1, 454, 85		12, 344, 250	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	27. 509586	1. 197146	0. 04076	9	0. 211904	203. 00
204.00	Cost to be allocated (per Wkst. B,			1, 37!	5	1, 888, 659	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part			0. 00003		0. 032421	205 00
	[11]			3.00003		0.002721	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1327 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (MEALS PLANT LINEN SERVICE (SQUARE (FTE'S) (SQUARE (POUNDS OF FEET) SERVED) LAUNDRY) FEET) 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE FOLLP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 44.690 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 644 14, 366 8 00 9.00 00900 HOUSEKEEPI NG 543 43, 402 9.00 644 10.00 01000 DI ETARY 2,569 100 2,569 100 10.00 01100 CAFETERI A 396, 972 11.00 621 11.00 621 C 0 01300 NURSING ADMINISTRATION 13.00 200 C 200 0 Λ 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY C 0 0 0 16.00 17.00 01700 SOCIAL SERVICE 140 C 140 0 5, 632 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 096 5, 415 100 82, 279 12,096 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 879 2,589 11,879 64,603 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C o 54.00 3, 273 1, 465 3, 273 46, 116 54.00 o 06000 LABORATORY 1, 988 60.00 1,988 44.086 60.00 79 06500 RESPIRATORY THERAPY 0 17, 168 65.00 826 62 826 65.00 65.01 06501 CARDI AC REHAB 793 C 793 0 4, 950 65.01 06502 PULMONARY 0 2, 970 65.02 65.02 0 C 0 5, 958 06503 SLEEP STUDY 828 253 828 65 03 65 03 66.00 06600 PHYSI CAL THERAPY 1,020 C Ω 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 904 1, 904 0 10, 977 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT ol 72.00 0 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 084 0 1, 084 0 10, 920 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 304 2, 304 0 3, 486 88.00 88 01 08802 RURAL HEALTH CLINIC II 40 0 88 01 0 0 0 08801 RURAL HEALTH CLINIC III 0 88.02 0 63 0 17, 554 88.02 08803 RURAL HEALTH CLINIC IV 0 C 0 0 88.03 88.03 0 ol 88.04 08804 RURAL HEALTH CLINIC V 0 0 0 88.04 0 0 08805 RURAL HEALTH CLINIC VI O 0 88 05 88 05 Γ 0 09000 CLI NI C 0 0 90.00 244 0 18,674 90.00 09001 ORTHOPAEDIC CLINIC 0 0 90.01 90.01 0 90.02 09002 SURGICAL CLINIC 0 0 0 0 90.02 09003 CARDI OLOGY CLINIC 90.03 0 0 C 8,086 90 03 90.04 09004 SENIOR CARE CLINIC 0 0 0 90.04 0 90.05 09005 SPECIALTY CLINIC 0 6,696 90.05 91.00 09100 EMERGENCY 2.493 0 91.00 2,657 2.657 46, 817 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 44, 450 14, 366 43, 162 100 396, 972 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 240 240 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES Ω C 0 0 0 192.00 192. 01 19201 OUTREACH 0 C 0 0 0 192.01 192. 02 19202 CLI NI C 0 192, 02 0 C 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 104, 782 234, 789 1, 122, 353 534, 221 928, 346 202. 00 Part I) 2. 338568 203. 00 203.00 69. 473753 16.343380 25.859477 5, 342. 210000 Unit cost multiplier (Wkst. B, Part I) 151, 212 204.00 Cost to be allocated (per Wkst. B, 24, 979 71.070 113, 460 43, 470 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3. 383576 1.738758 1.637482 1. 134. 600000 0. 109504 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)

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1327 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Cost Center Description NURSI NG MEDI CAL SOCI AL NONPHYSI CI AN ADMI NI STRATI O SERVI CE RECORDS & **ANESTHETI STS** LI BRARY (TOTAL (ASSI GNED Ν (NURSE FTE'S) (TIME PATIENT DAYS) TIME) SPENT) 13.00 16.00 17.00 19.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11.00 01300 NURSING ADMINISTRATION 13.00 193, 699 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 545 16.00 01700 SOCIAL SERVICE 17.00 0 1,602 17.00 C 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 C C 100 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 82, 279 362 1, 602 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 64,603 27 0 0 50.00 05300 ANESTHESI OLOGY 0 53.00 0 100 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 8 0 0 9 60.00 06000 LABORATORY 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 2 0 0 65.00 0 65.01 06501 CARDI AC REHAB 0 0 0 0 65.01 0 06502 PULMONARY 0 0 65 02 65 02 06503 SLEEP STUDY 0 0 65.03 C 65.03 66.00 06600 PHYSI CAL THERAPY 0 0 10 66.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 Ω 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 С 0 0 88.00 08802 RURAL HEALTH CLINIC II 0 0 0 0 88.01 11 88 01 0 88.02 08801 RURAL HEALTH CLINIC III 18 0 88.02 08803 RURAL HEALTH CLINIC IV 0 88.03 14 88.03 0 88.04 08804 RURAL HEALTH CLINIC V 00000 C 0 88.04 0 88.05 08805 RURAL HEALTH CLINIC VI 0 88 05 0 90.00 09000 CLI NI C 90.00 90.01 09001 ORTHOPAEDIC CLINIC 75 0 0 90 01 0 09002 SURGICAL CLINIC C 0 90.02 90.02 09003 CARDI OLOGY CLINIC 0 90.03 C 90.03 90.04 09004 SENIOR CARE CLINIC 0 0 0 0 90.04 09005 SPECIALTY CLINIC 0 90.05 C 0 90.05 0 91.00 09100 EMERGENCY 46.817 C 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 95.00 0 0 0 0 95.00 113. 00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 193, 699 545 1,602 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 C 0 0 192.00 192. 01 19201 OUTREACH 0 0 192.01 C 0 192. 02 19202 CLI NI C 0 C 0 0 192.02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 993, 877 202.00 Cost to be allocated (per Wkst. B, 951, 408 373, 389 439, 114 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 911786 3, 658. 489908 233. 076779 4, 391. 140000 203.00 Cost to be allocated (per Wkst. B, 204.00 204.00 31, 472 53, 976 14,833 11,801 Part II) 205.00 99. 038532 9. 259051 118.010000 205.00 Unit cost multiplier (Wkst. B, Part 0.162479 11) 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)

Heal th	Financial Systems WAR	BASH GENERAL HO	<u>ISPITAL DISTRIC</u>	T	In Lie	u of Form CMS-:	<u> 2552-10</u>
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-1327	Peri od:	Worksheet C	
					From 01/01/2023	Part I	
					To 12/31/2023	Date/Time Pre 5/17/2024 11:	eparea:
			Ti +l e	e XVIII	Hospi tal	Cost	UZ alli
			11 (1)	XVIII	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	COST CONTON DESCRIPTION	(from Wkst.	Adj.	10141 00313	Di sal I owance	10101 00313	
		B, Part I,	,, .		Di Gai i Gilano		
		col . 26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	7, 857, 526		7, 857, 52	26 0	0	30.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00	05000 OPERATING ROOM	6, 180, 835		6, 180, 83	35 0	0	50.00
53.00	05300 ANESTHESI OLOGY	504, 602		504, 60		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 042, 411		4, 042, 4	11 0	0	54.00
60.00	06000 LABORATORY	4, 339, 776		4, 339, 77		0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 023, 462	l c	1, 023, 46	52 0	0	65.00
65. 01	06501 CARDI AC REHAB	372, 839				0	65. 01
	06502 PULMONARY	264, 388	l			0	
	06503 SLEEP STUDY	537, 712	ł			0	65.03
	06600 PHYSI CAL THERAPY	3, 205, 852	l c	3, 205, 85		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 896, 960	-	1, 896, 96		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	4, 245, 915	ł	4, 245, 9		0	
	07300 DRUGS CHARGED TO PATIENTS	7, 992, 829		7, 992, 82		0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	688, 539		688, 53	39 0	0	88.00
88. 01	08802 RURAL HEALTH CLINIC II	3, 590, 852		3, 590, 85	52 0	0	88. 01
88. 02	08801 RURAL HEALTH CLINIC III	1, 646, 292		1, 646, 29	92 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 764, 526		1, 764, 52	26	0	88. 03
	08804 RURAL HEALTH CLINIC V	1, 368, 990		1, 368, 99		0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	1, 086, 791		1, 086, 79		0	88. 05
	09000 CLI NI C	1, 550, 529		1, 550, 52		0	90.00
90. 01	09001 ORTHOPAEDIC CLINIC	4, 657, 338		4, 657, 33	38 0	0	90. 01
90. 02	09002 SURGI CAL CLINIC	913, 645		913, 64		0	90.02
90. 03	09003 CARDI OLOGY CLI NI C	238, 163		238, 16	63 0	0	90. 03
	09004 SENI OR CARE CLI NI C	396, 055		396, 05		0	
90.05	09005 SPECIALTY CLINIC	989, 923	l	989, 92		0	90.05
	09100 EMERGENCY	4, 917, 627		4, 917, 62		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	711, 721		711, 72		0	
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	2, 721, 551		2, 721, 55	51 0	0	95.00
	SPECIAL PURPOSE COST CENTERS	, , , , , , , , , , , ,					1
	11300 NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	69, 707, 649	C	69, 707, 64	19 0	0	200.00
201.00	Less Observation Beds	711, 721		711, 72			201.00
202.00	Total (see instructions)	68, 995, 928	C	68, 995, 92	28 0		202.00
			'		1	•	

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1327 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 941, 016 2, 941, 016 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 3, 750, 919 26, 732, 439 0.000000 50.00 30, 483, 358 0.202761 50.00 53.00 05300 ANESTHESI OLOGY 518.483 4, 292, 877 4, 811, 360 0.104877 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 807.075 29, 040, 737 0.139198 54.00 28, 233, 662 0.000000 54 00 60.00 06000 LABORATORY 1, 380, 711 18, 008, 731 19, 389, 442 0. 223822 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 317, 367 1, 510, 342 1, 827, 709 0.559970 0.000000 65.00 06501 CARDI AC REHAB 427, 210 428, 210 0.870692 1.000 0.000000 65.01 65.01 06502 PULMONARY 0.000000 65.02 1,065 166, 449 167, 514 1.578304 65 02 65.03 06503 SLEEP STUDY 1, 952, 952 1, 952, 952 0.275333 0.000000 65.03 66.00 06600 PHYSI CAL THERAPY 1, 106, 150 9, 684, 262 10, 790, 412 0. 297102 0.000000 66.00 1, 107, 316 4, 078, 421 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 185, 737 0.365803 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 3,003,817 14, 860, 313 17, 864, 130 0. 237678 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 398, 912 33, 912, 491 0.000000 73.00 32, 513, 579 0.235690 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 494, 454 494, 454 08800 RURAL HEALTH CLINIC 88.00 08802 RURAL HEALTH CLINIC II 0 2, 423, 034 2, 423, 034 88.01 88.01 0 88.02 08801 RURAL HEALTH CLINIC III 958, 969 958, 969 88.02 0 08803 RURAL HEALTH CLINIC IV 88.03 1,090,473 1,090,473 88.03 88.04 08804 RURAL HEALTH CLINIC V 0 1, 425, 046 1, 425, 046 88.04 88.05 08805 RURAL HEALTH CLINIC VI 0 603, 581 603, 581 88.05 90.00 09000 CLI NI C 25 1, 205, 395 1, 205, 420 1. 286298 0.000000 90.00 09001 ORTHOPAEDIC CLINIC 90 01 300 3, 542, 867 3, 543, 167 1 314456 0.000000 90 01 90.02 09002 SURGI CAL CLINIC 75 364, 202 364, 277 2.508105 0.000000 90.02 09003 CARDIOLOGY CLINIC 250 227, 876 1.045143 90.03 227, 626 0.000000 90.03 09004 SENIOR CARE CLINIC 340, 126 0.000000 90.04 90.04 10 340, 116 1.164436 09005 SPECIALTY CLINIC 5.341840 90.05 25 185, 290 185, 315 0.000000 90.05 91.00 09100 EMERGENCY 54,080 6,061,346 6, 115, 426 0.804135 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 362, 402 362, 402 1.963899 0.000000 92.00 0 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 09500 AMBULANCE SERVICES 0 2, 755, 514 2, 755, 514 0. 987675 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 164, 501, 552 180, 890, 148 16 388 596 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 201.00

16, 388, 596

164, 501, 552

180, 890, 148

202.00

Total (see instructions)

				To 12/31/2023	Date/Time Pre	epared:
			Title XVIII	Hospi tal	5/17/2024 11: Cost	02 am
	Cost Center Description	PPS Inpatient	THE ATTE	1103pi tui	0031	
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS	'				1
50.00	05000 OPERATI NG ROOM	0. 000000				50.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
65. 01	06501 CARDI AC REHAB	0. 000000				65. 01
65.02	06502 PULMONARY	0. 000000				65. 02
65.03	06503 SLEEP STUDY	0. 000000				65. 03
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	OUTPATIENT SERVICE COST CENTERS					1
88.00	08800 RURAL HEALTH CLINIC					88. 00
88. 01	08802 RURAL HEALTH CLINIC II					88. 01
88. 02	08801 RURAL HEALTH CLINIC III					88. 02
88. 03	08803 RURAL HEALTH CLINIC IV					88. 03
88. 04	08804 RURAL HEALTH CLINIC V					88. 04
88. 05	08805 RURAL HEALTH CLINIC VI					88. 05
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 ORTHOPAEDI C CLI NI C	0. 000000				90. 01
90.02	09002 SURGI CAL CLI NI C	0. 000000				90. 02
90. 03	09003 CARDI OLOGY CLI NI C	0. 000000				90. 03
90.04	09004 SENI OR CARE CLI NI C	0. 000000				90. 04
90.05	09005 SPECIALTY CLINIC	0. 000000				90. 05
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 000000				95. 00
	SPECIAL PURPOSE COST CENTERS	1				
	11300 INTEREST EXPENSE					113.00
200.00	. , , , , , , , , , , , , , , , , , , ,					200.00
201.00	l l					201.00
202.00	Total (see instructions)					202. 00

Health Financial Systems V	WABASH GENERAL HO	SPITAL DISTRIC	T	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	norod.
				10 12/31/2023	5/17/2024 11:	:pareu. O2 am
		Ti tl	e XIX	Hospi tal	Cost	02 4111
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 857, 526		7, 857, 52	6 0	7, 857, 526	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 180, 835		6, 180, 83		6, 180, 835	
53. 00 05300 ANESTHESI OLOGY	504, 602		504, 60		504, 602	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 042, 411		4, 042, 41		4, 042, 411	1
60. 00 06000 LABORATORY	4, 339, 776		4, 339, 77		4, 339, 776	
65. 00 06500 RESPI RATORY THERAPY	1, 023, 462	0	.,,		1, 023, 462	1
65. 01 06501 CARDI AC REHAB	372, 839	0			372, 839	
65. 02 06502 PULMONARY	264, 388	0			264, 388	
65. 03 06503 SLEEP STUDY	537, 712	0	1 00., ,		537, 712	
66. 00 06600 PHYSI CAL THERAPY	3, 205, 852	0	3, 205, 85		3, 205, 852	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 896, 960		1, 896, 960		1, 896, 960	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 245, 915		4, 245, 91!		4, 245, 915	
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 992, 829		7, 992, 82	9 0	7, 992, 829	73.00
OUTPATIENT SERVICE COST CENTERS	1		1			
88. 00 08800 RURAL HEALTH CLINIC	688, 539		688, 539		688, 539	
88. 01 08802 RURAL HEALTH CLINIC II	3, 590, 852		3, 590, 85		3, 590, 852	
88. 02 08801 RURAL HEALTH CLINIC III	1, 646, 292		1, 646, 29		1, 646, 292	
88. 03 08803 RURAL HEALTH CLINIC IV	1, 764, 526		1, 764, 520		1, 764, 526	
88. 04 08804 RURAL HEALTH CLINIC V	1, 368, 990		1, 368, 990		1, 368, 990	
88. 05 08805 RURAL HEALTH CLINIC VI	1, 086, 791		1, 086, 79		1, 086, 791	1
90. 00 09000 CLINIC	1, 550, 529		1, 550, 529		1, 550, 529	
90. 01 09001 0RTHOPAEDI C CLI NI C	4, 657, 338		4, 657, 33		4, 657, 338	
90. 02 09002 SURGI CAL CLI NI C	913, 645		913, 64		913, 645	1
90. 03 09003 CARDI OLOGY CLINI C	238, 163		238, 16		238, 163	1
90. 04 09004 SENI OR CARE CLI NI C	396, 055		396, 05		396, 055	
90. 05 09005 SPECIALTY CLINIC	989, 923		989, 92		989, 923	
91. 00 09100 EMERGENCY	4, 917, 627		4, 917, 62		4, 917, 627	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	711, 721		711, 72	1	711, 721	92.00
OTHER REIMBURSABLE COST CENTERS				.1		l
95. 00 09500 AMBULANCE SERVICES	2, 721, 551		2, 721, 55	1 0	2, 721, 551	95.00
SPECIAL PURPOSE COST CENTERS						110 05
113. 00 11300 INTEREST EXPENSE		_	(0.707	_		113.00
200.00 Subtotal (see instructions)	69, 707, 649	0	,,		69, 707, 649	
201.00 Less Observation Beds	711, 721	_	711, 72		711, 721	
202.00 Total (see instructions)	68, 995, 928	0	68, 995, 92	8 0	68, 995, 928	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1327 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 941, 016 2, 941, 016 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.000000 50.00 3, 750, 919 26, 732, 439 30, 483, 358 0.202761 50.00 53.00 05300 ANESTHESI OLOGY 518.483 4, 292, 877 4, 811, 360 0.104877 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 807.075 29, 040, 737 0.139198 54.00 28, 233, 662 0.000000 54 00 60.00 06000 LABORATORY 1, 380, 711 18, 008, 731 19, 389, 442 0. 223822 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 317, 367 1, 510, 342 1, 827, 709 0.559970 0.000000 65.00 06501 CARDI AC REHAB 427, 210 428, 210 1.000 0.870692 0.000000 65.01 65.01 06502 PULMONARY 65.02 1,065 166, 449 167, 514 1.578304 0.000000 65 02 65.03 06503 SLEEP STUDY 1, 952, 952 1, 952, 952 0.275333 0.000000 65.03 66.00 06600 PHYSI CAL THERAPY 1, 106, 150 9, 684, 262 10, 790, 412 0. 297102 0.000000 66.00 4, 078, 421 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 365803 1, 107, 316 5, 185, 737 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 3,003,817 14, 860, 313 17, 864, 130 0. 237678 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 398, 912 33, 912, 491 73.00 32, 513, 579 0.235690 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 494, 454 494, 454 1. 392524 0.000000 88.00 08800 RURAL HEALTH CLINIC 08802 RURAL HEALTH CLINIC II 0 2, 423, 034 2, 423, 034 1. 481965 0.000000 88.01 88.01 0 88.02 08801 RURAL HEALTH CLINIC III 958, 969 958, 969 1.716731 0.000000 88.02 0 08803 RURAL HEALTH CLINIC IV 88.03 1,090,473 1,090,473 1.618129 0.000000 88.03 88.04 08804 RURAL HEALTH CLINIC V 0 1, 425, 046 1, 425, 046 0. 960664 0.000000 88.04 88.05 08805 RURAL HEALTH CLINIC VI 0 603, 581 603, 581 1.800572 0.000000 88.05 90.00 09000 CLI NI C 25 1, 205, 395 1, 205, 420 1. 286298 0.000000 90.00 09001 ORTHOPAEDIC CLINIC 90 01 300 3, 542, 867 3, 543, 167 1.314456 0.000000 90 01 90.02 09002 SURGI CAL CLINIC 75 364, 202 364, 277 2.508105 0.000000 90.02 09003 CARDIOLOGY CLINIC 250 227, 876 1.045143 90.03 227, 626 0.000000 90.03 09004 SENIOR CARE CLINIC 0.000000 90.04 10 340, 116 340, 126 1.164436 90.04 09005 SPECIALTY CLINIC 90.05 25 185, 290 185, 315 5.341840 0.000000 90.05 91.00 09100 EMERGENCY 54,080 6,061,346 6, 115, 426 0.804135 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 362, 402 362, 402 1.963899 0.000000 92.00 0 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 09500 AMBULANCE SERVICES 0 2, 755, 514 2, 755, 514 0. 987675 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 180, 890, 148 16 388 596 164, 501, 552 200.00 Subtotal (see instructions) 201.00 201.00 Less Observation Beds 202.00 16, 388, 596 164, 501, 552 180, 890, 148 202.00

Total (see instructions)

				To 12/31/2023		
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS				30.	. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.	. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.	. 00
60.00	06000 LABORATORY	0. 000000				. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000				. 00
65. 01	06501 CARDI AC REHAB	0. 000000				. 01
65.02	06502 PULMONARY	0. 000000			65.	. 02
65. 03	06503 SLEEP STUDY	0. 000000			65.	. 03
66.00	06600 PHYSI CAL THERAPY	0. 000000				. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.	. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			72.	. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	. 00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0. 000000			88.	. 00
88. 01	08802 RURAL HEALTH CLINIC II	0. 000000				. 01
88. 02	08801 RURAL HEALTH CLINIC III	0. 000000				. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0. 000000				. 03
	08804 RURAL HEALTH CLINIC V	0. 000000				. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0. 000000				. 05
90.00	09000 CLI NI C	0. 000000				. 00
90. 01	09001 ORTHOPAEDI C CLI NI C	0. 000000				. 01
	09002 SURGI CAL CLI NI C	0. 000000				. 02
	09003 CARDI OLOGY CLI NI C	0. 000000				. 03
90.04	09004 SENI OR CARE CLI NI C	0. 000000				. 04
	09005 SPECIALTY CLINIC	0. 000000				. 05
91.00	09100 EMERGENCY	0. 000000			91.	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.	. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000			95.	. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE				113.	
200.00					200.	
201.00					201.	
202.00	Total (see instructions)				202.	. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 14-1327 Peri od: Worksheet D From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Title XVIII Hospi tal Cost Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges Related Cost (column 3 x (from Wkst. Program column 4) (from Wkst. C, Part I, (col. 1 ÷ Charges B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4. 00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 1, 794, 896 50 00 0.027745 50 00 05000 OPERATING ROOM 845, 776 30, 483, 358 49.799 53.00 05300 ANESTHESI OLOGY 55, 789 4, 811, 360 0.011595 264, 109 3,062 53.00 05400 RADI OLOGY-DI AGNOSTI C 465, 021 0.016013 54.00 29, 040, 737 476, 147 7,625 54.00 06000 LABORATORY 874, 895 13, 079 289, 850 19, 389, 442 0.014949 60.00 60.00 06500 RESPIRATORY THERAPY 1, 827, 709 0.059500 65.00 108, 748 203, 590 12, 114 65.00 65.01 06501 CARDI AC REHAB 33, 987 428, 210 0.079370 0 0 65.01 65.02 06502 PULMONARY 7, 215 167, 514 0.043071 7 65.02 0 41, 904 1, 952, 952 0.021457 65.03 06503 SLEEP STUDY 65.03 0 Ω 66.00 06600 PHYSI CAL THERAPY 100, 772 10, 790, 412 0.009339 479, 016 4, 474 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 116, 193 5, 185, 737 0.022406 572, 297 12,823 71.00 10, 198 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 113, 587 0.006358 1, 604, 010 72.00 17, 864, 130 07300 DRUGS CHARGED TO PATIENTS 33, 912, 491 0.007421 787, 383 5, 843 73.00 251, 660 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 87, 665 494, 454 0. 177297 0 0 88.00 2, 423, 034 0 88.01 08802 RURAL HEALTH CLINIC II 96, 220 0.039711 88.01 0 88.02 08801 RURAL HEALTH CLINIC III 45,008 958, 969 0.046934 0 88.02 08803 RURAL HEALTH CLINIC IV 47, 263 1,090,473 0.043342 o 88.03 88.03 0 08804 RURAL HEALTH CLINIC V 36, 651 1, 425, 046 0.025719 0 88.04 88.04 0 08805 RURAL HEALTH CLINIC VI 29, 096 88.05 603, 581 0.048206 0 0 88.05 90.00 09000 CLI NI C 42,708 1, 205, 420 0.035430 11 0 90.00 09001 ORTHOPAEDIC CLINIC 124, 884 0.035246 90. 01 3, 543, 167 262 90.01 90 02 09002 SURGICAL CLINIC 24, 479 364, 277 0.067199 3 90.02 42 09003 CARDIOLOGY CLINIC 90.03 90.03 6, 782 227, 876 0.029762 217 6 90.04 09004 SENIOR CARE CLINIC 10, 601 340, 126 0.031168 0 90.04 09005 SPECIALTY CLINIC 90.05 26, 803 185, 315 0.144635 7 90.05 1 09100 EMERGENCY 91 00 274,604 6, 115, 426 0.044903 6 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 69, 426 362, 402 0.191572 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 7, 056, 896 3, 352, 692 175, 193, 618 119, 036 200. 00 200.00 Total (lines 50 through 199)

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems WABASH GENERAL HOSPITAL DISTRICT

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1327 THROUGH COSTS

				10 12/31/2023	Date/lime Pre 5/17/2024 11:	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	439, 114	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	0	0	65.00
65. 01 06501 CARDI AC REHAB	0	0	1	0	0	65. 01
65. 02 06502 PULMONARY	0	0	1	0	0	65. 02
65. 03 06503 SLEEP STUDY	0	0	1	0	0	65. 03
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88.01 08802 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88.02 08801 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	0	0		0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0	0	1	0	0	88. 05
90. 00 09000 CLI NI C	0	0	1	0	0	90.00
90. 01 09001 ORTHOPAEDI C CLI NI C	0	0		0	0	90. 01
90. 02 09002 SURGI CAL CLI NI C	0	0		0	0	90. 02
90. 03 09003 CARDI OLOGY CLI NI C	0	0		0	0	90. 03
90. 04 09004 SENI OR CARE CLI NI C	0	0	1	0	0	90. 04
90. 05 09005 SPECIALTY CLINIC	0	0	1	0	0	90. 05
91. 00 09100 EMERGENCY	0	0	1	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	439, 114	0	1	0 0	0	200. 00

Period: Worksheet D From 01/01/2023 Part IV THROUGH COSTS

TIROUGH COSTS				To 12/31/2023	Date/Time Pre 5/17/2024 11:	pared: 02 am
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_	_				
50. 00 05000 OPERATI NG ROOM	0	_		30, 483, 358	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	439, 114		4, 811, 360	0. 091266	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	29, 040, 737	0. 000000	
60. 00 06000 LABORATORY	0	0)	19, 389, 442	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0)	1, 827, 709		
65. 01 06501 CARDI AC REHAB	0	0)	210 428, 210		
65. 02 06502 PULMONARY	0	0)	167, 514	0. 000000	
65. 03 06503 SLEEP STUDY	0	0		1, 952, 952	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0)	10, 790, 412	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	5, 185, 737	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		1	17, 864, 130		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0)	33, 912, 491	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	T	1				
88. 00 08800 RURAL HEALTH CLINIC	0			94, 454	0. 000000	
88. 01 08802 RURAL HEALTH CLINIC II	0	0		2, 423, 034	0. 000000	
88. 02 08801 RURAL HEALTH CLINIC III	0	0		958, 969	0. 000000	
88.03 08803 RURAL HEALTH CLINIC IV	0	0)	1, 090, 473	0. 000000	
88. 04 08804 RURAL HEALTH CLINIC V	0	0)	1, 425, 046	0. 000000	
88. 05 08805 RURAL HEALTH CLINIC VI	0	0)	0 603, 581	0. 000000	
90. 00 09000 CLI NI C	0	0)	1, 205, 420	0. 000000	
90. 01 09001 ORTHOPAEDI C CLI NI C	0	0)	3, 543, 167	0. 000000	
90. 02 09002 SURGI CAL CLI NI C	0	0)	364, 277	0. 000000	
90. 03 09003 CARDI OLOGY CLI NI C	0	0)	227, 876	0. 000000	
90.04 09004 SENIOR CARE CLINIC	0	0)	340, 126		
90. 05 09005 SPECIALTY CLINIC	0	0)	185, 315	0. 000000	
91. 00 09100 EMERGENCY	0			6, 115, 426		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)[362, 402	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS		1				
95. 00 09500 AMBULANCE SERVICES		400 111		475 400 (10		95.00
200.00 Total (lines 50 through 199)	0	439, 114	· (0 175, 193, 618		200. 00

 Heal th Financial
 Systems
 WABASH GENERAL
 HOSPITAL DISTRICT

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 14-1327
 THROUGH COSTS

				To 12/31/2023	Date/Time Pre 5/17/2024 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 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	1, 794, 896		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	264, 109	24, 10	4 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	476, 147		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	874, 895		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	203, 590		0	0	65.00
65. 01 06501 CARDI AC REHAB	0. 000000	0		0	0	65. 01
65. 02 06502 PULMONARY	0. 000000	7		0	0	65. 02
65. 03 06503 SLEEP STUDY	0. 000000	0		0	0	65. 03
66. 00 06600 PHYSI CAL THERAPY	0. 000000	479, 016		0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	572, 297		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	1, 604, 010		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	787, 383		0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88.01 08802 RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
88.02 08801 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000	0		0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	0. 000000	0		0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0. 000000	0		0	0	88. 05
90. 00 09000 CLI NI C	0. 000000	11		0	0	90.00
90. 01 09001 ORTHOPAEDI C CLI NI C	0. 000000	262		0	0	90. 01
90. 02 09002 SURGI CAL CLI NI C	0. 000000	42		0	0	90. 02
90. 03 09003 CARDI OLOGY CLI NI C	0. 000000	217		0	0	90. 03
90. 04 09004 SENI OR CARE CLI NI C	0. 000000	1		0	0	90. 04
90. 05 09005 SPECIALTY CLINIC	0. 000000	7		0	0	90.05
91. 00 09100 EMERGENCY	0. 000000	6		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS				•		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		7, 056, 896	24, 10	4 0	0	200.00
			•	•		•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1327 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/17/2024 11:02 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 077, 981 0. 202761 50.00 05300 ANESTHESI OLOGY 2 0.104877 1, 461, 433 53.00 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0. 139198 10, 286, 551 0 54.00 60.00 06000 LABORATORY 0. 223822 6, 651, 796 0 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.559970 646, 954 0 65.00 65.01 06501 CARDI AC REHAB 0.870692 273, 922 0 65.01 65.02 06502 PULMONARY 1.578304 0 66, 016 0 65.02 65.03 06503 SLEEP STUDY 0. 275333 482, 350 o 0 65.03 o 66.00 06600 PHYSI CAL THERAPY 0. 297102 0 3, 027, 392 0 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 365803 0 0 71.00 1, 583, 383 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.237678 0 6, 921, 361 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0. 235690 17, 032, 090 3, 323 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08802 RURAL HEALTH CLINIC II 88.01 08801 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88 03 88 03 08804 RURAL HEALTH CLINIC V 88.04 88.04 88.05 08805 RURAL HEALTH CLINIC VI 88.05 90.00 09000 CLI NI C 1. 286298 467, 674 0 90.00 0 3 0 09001 ORTHOPAEDIC CLINIC 90 01 1 314456 0 1, 377, 337 90.01 0 90.02 09002 SURGI CAL CLINIC 2.508105 141, 759 0 90.02 90.03 09003 CARDI OLOGY CLINIC 1.045143 89, 769 0 0 90.03 0 09004 SENIOR CARE CLINIC 1. 164436 0 313, 792 90.04 90.04 0 90.05 09005 SPECIALTY CLINIC 5.341840 0 73,059 0 90.05 0 91.00 09100 EMERGENCY 0.804135 0 1, 885, 442 155 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.963899 150, 461 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 987675 95.00 200.00 Subtotal (see instructions) 0 63, 010, 522 0 200.00 3, 483 201.00 Less PBP Clinic Lab. Services-Program 201.00 0 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 63, 010, 522 3.483

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1327 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 043, 422 50.00 05300 ANESTHESI OLOGY 53.00 153, 271 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1, 431, 867 54.00 60.00 06000 LABORATORY 1, 488, 818 0 60.00 65.00 06500 RESPIRATORY THERAPY 362, 275 0 65.00 0 06501 CARDI AC REHAB 65.01 238, 502 65.01 0 65.02 06502 PULMONARY 104, 193 65.02 65.03 06503 SLEEP STUDY 132, 807 65.03 0 66.00 06600 PHYSI CAL THERAPY 899, 444 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 579, 206 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 645, 055 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 014, 293 73.00 73.00 783 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08802 RURAL HEALTH CLINIC II 88.01 08801 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88 03 88 03 08804 RURAL HEALTH CLINIC V 88.04 88.04 88.05 08805 RURAL HEALTH CLINIC VI 88.05 09000 CLI NI C 90.00 601, 568 90.00 09001 ORTHOPAEDIC CLINIC 90 01 1, 810, 449 90 01 90.02 09002 SURGI CAL CLINIC 355, 546 90.02 90.03 09003 CARDI OLOGY CLINIC 93, 821 0 90.03 90.04 09004 SENIOR CARE CLINIC 365, 391 90.04 0 09005 SPECIALTY CLINIC 90.05 390, 269 90.05 0 91.00 09100 EMERGENCY 1, 516, 150 125 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 295, 490 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 18, 521, 837 912 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

18, 521, 837

912

202.00

202.00

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1327 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/17/2024 11:02 am Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 234, 504 0. 202761 50.00 05300 ANESTHESI OLOGY 0 42.853 53.00 0.104877 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0. 139198 409, 651 0 54.00 60.00 06000 LABORATORY 0. 223822 0 319, 991 0 0 0 0 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.559970 0 28, 919 0 65.00 65.01 06501 CARDI AC REHAB 0.870692 0 0 65.01 Ω 65.02 06502 PULMONARY 1.578304 0 0 0 65.02 65.03 06503 SLEEP STUDY 0. 275333 29, 501 0 65.03 66.00 06600 PHYSI CAL THERAPY 0. 297102 0 159, 819 0 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 365803 0 71.00 54, 578 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.237678 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 108, 597 0 73.00 73.00 0. 235690 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08802 RURAL HEALTH CLINIC II 88.01 08801 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88 03 88 03 08804 RURAL HEALTH CLINIC V 88.04 88.04 88.05 08805 RURAL HEALTH CLINIC VI 88.05 90.00 09000 CLI NI C 1. 286298 54, 992 0 90.00 0 0 09001 ORTHOPAEDIC CLINIC 90 01 1. 314456 0 90.01 0 0 90.02 09002 SURGI CAL CLINIC 2.508105 0 0 90.02 90.03 09003 CARDI OLOGY CLINIC 1.045143 0 0 0 0 90.03 09004 SENIOR CARE CLINIC 1. 164436 0 90.04 90.04 0 0 09005 SPECIALTY CLINIC 90.05 5.341840 0 0 90.05 0 0 91.00 09100 EMERGENCY 0.804135 0 179, 212 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1.963899 192 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 987675 95.00 200.00 Subtotal (see instructions) 1, 622, 809 0 0 200.00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 C Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 0 0 1, 622, 809

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1327 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/17/2024 11:02 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 47, 548 50.00 05300 ANESTHESI OLOGY 4, 494 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 57, 023 0 54.00 54.00 60.00 06000 LABORATORY 71,621 0 60.00 65.00 06500 RESPIRATORY THERAPY 16, 194 0 65.00 01 06501 CARDI AC REHAB 65.01 65.01 0 0 65.02 06502 PULMONARY 0 65.02 65.03 06503 SLEEP STUDY 8, 123 65.03 0 66.00 06600 PHYSI CAL THERAPY 47, 483 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 19, 965 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 25, 595 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08802 RURAL HEALTH CLINIC II 88.01 08801 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88 03 88 03 08804 RURAL HEALTH CLINIC V 88.04 88.04 88.05 08805 RURAL HEALTH CLINIC VI 88.05 09000 CLI NI C 90.00 70, 736 90.00 09001 ORTHOPAEDIC CLINIC 90 01 0 90 01 0 90.02 09002 SURGI CAL CLINIC 0 0 90.02 90.03 09003 CARDI OLOGY CLINIC 0 0 90.03 90.04 09004 SENIOR CARE CLINIC 0 0 90.04 09005 SPECIALTY CLINIC 90.05 0 90.05 0 91.00 09100 EMERGENCY 144, 111 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 377 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 513, 270 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 0 Only Charges 202.00 202.00 Net Charges (line 200 - line 201) 0

513, 270

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1327	Peri od: From 01/01/2023	Worksheet D-1
			To 12/31/2023	Date/Time Prepared: 5/17/2024 11:02 am
		Title XVIII	Hospi tal	Cost

Cost Center Description 1,00			Title XVIII	Hospi tal	5/17/2024 11: Cost	02 am
PART 1 - ALL PROVIDER CONFORMETS		Cost Center Description	IT LITE AVITE	поѕрі таі	COST	
INPATE IERT DAYS		<u> </u>			1. 00	
Inpattient days (Including private room days and swing-bed days, excluding newborn)						
Impatient days (Including private room days, excluding safing-bed and newborn days) 1,807 2,00	1. 00		rs. excluding newborn)		2, 392	1. 00
do not complete this line. 1. 602						
5.00 Semi-private room days (excluding sming-bed and observation bed days) 1.602 4.00	3.00		ys). If you have only pr	rivate room days,	0	3.00
Total swing-bod SNF type inpatient days (including private room days) through December 31 of the cost of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost or porting period (ir calendar year, enter 0 on this line) 10 reporting period (ir calendar year, enter 0 on this line) 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 10 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11 Cost of the cost reporting period (if calendar year, enter 0 on this line) 12 Cost of the cost reporting period (if calendar year, enter 0 on this line) 13 Cost of type inpatient days applicable to title SVIII only (including private room days) 14 Cost of the cost reporting period (if calendar year, enter 0 on this line) 15 Cost of type inpatient days applicable to title SVIII only (including private room days) 16 Cost of type inpatient days applicable to title SVIII only (including private room days) 17 Cost of the cost reporting period (if calendar year, enter 0 on this line) 18 Cost of type inpatient days applicable to titles V or XIX only (including private room days) 19 Cost of the cost reporting period (including private room days) 10 Cost of type inpatient days applicable to titles V or XIX only (including private room days) 11 Cost of type inpatient days applicable to titles V or XIX only (including private room days) 12 Cost of type inpatient days applicable to the Program (excluding axing-bed days) 13 Cost of type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 14 Cost of type inpatient days applicable to services after December 31 of the cost reporting period (including priva	4 00		- d - d \		1 (00	4 00
reporting period (1f calendar year, enter 0 on this line) 8. 00 Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line) 8. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days aplicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (1see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (1see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (1see instructions) 13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14. 00 Medically necessary privater room days applicable to titles V or XIX only (including private room days) 15. 00 Interest of the cost reporting period (1see instructions) 16. 00 Interest of the cost reporting period (1see instructions) 17. 00 Vering-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (1see instructions) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (1see instructions) 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (1see instructions) 19. 00 Wedicare rate for swing-bed SNF services applicable				or 21 of the cost		
reporting period (if calendar year, enter 0 on this line) 10 Total swing-bod Nr type inpatient days (including private room days) through becember 31 of the cost reporting period in the street of th	3.00		om days) thi odgir becembe	si 31 di the cost	440	3.00
7.00 Total swing-bed NF type inpatient days (including private room days) shrough Becember 31 of the cost reporting period of (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Samphed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,147 on 10.00 Samphed SNF type inpatient days applicable to title WIII only (including private room days) after 10.00 Samphed SNF type inpatient days applicable to title WIII only (including private room days) after 10.00 Samphed SNF type inpatient days applicable to title WIII only (including private room days) after 10.00 Samphed NF type inpatient days applicable to title V or XIX only (including private room days) 11.00 Samphed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this Iline) 10.00 Samphed NF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Days (title V or XIX only) 11.00 Samphed NF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Days (title V or XIX only) 11.00 Days (title V	6.00	3	om days) after December	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 03 Wing-bed SMF type impatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Word-becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15. 00 Total mursery days (title V or XIX only) 16. 00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days) 17. 00 Word-becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Redically necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 19. 00 Word-becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 19. 00 Word-becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 19. 00 Word-becember 31 of the cost (if Year) and year year year year year year year year						
Total swing bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)	7. 00		m days) through December	31 of the cost	137	7.00
reporting period (if calendar year, enter 0 on this line) 10 00 Table part of the days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions) 11 00 Swing-bed SNF type inpatient days applicable to calendar year, enter on this line) 12 00 Swing-bed SNF type inpatient days applicable to calendar year, enter on this line) 13 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after on through December 31 of the cost reporting period 13 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15 00 Total nursery days (title V or XIX only) 16 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17 00 Mursery days (title V or XIX only) 18 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 19 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 19 00 Medically reported and the private room days applicable to services through December 31 of the cost reporting period (including private room days) 19 00 Medical room of the private room days applicable to services after December 31 of the cost reporting period (including private room days) 19 00 Medical room of the private room days applicable to services through December 31 of the cost reporting period (including private room days applicable to services applicable to services after December 31 of the cost reporting period (line of the private room including private room days applicable to SNF type services after December 31 of the cost reporting period (line of the	8 00		m days) after December 3	R1 of the cost	0	8 00
newborn days) (see instructions) 10.00 Sing-Ded SIN Type inpatient days applicable to Title XVIII only (including private room days) 11.00 Sing-Ded SIN Type inpatient days applicable to Title XVIII only (including private room days) after 11.00 Sing-Ded SIN Type inpatient days applicable to Title XVIII only (including private room days) after 12.00 Sing-Ded Ni Type inpatient days applicable to Titles V or XIX only (including private room days) 12.00 Sing-Ded Ni Type inpatient days applicable to Titles V or XIX only (including private room days) 13.00 Sing-Ded Ni Type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Sing-Ded Ni Type inpatient days applicable to Titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Sing Sing Sing Sing Sing Sing Sing Sing	0.00		days, a. ts. bessinbe. t		· ·	0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after become should be the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to services through December 31 of the cost 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nursery days (title V or XIX only) 19.00 Nursery day	9. 00		o the Program (excluding	g swing-bed and	1, 147	9. 00
through December 31 of the cost reporting period (see Instructions) 1.00 Sing-bed SNF type inpatient days applicable to title XV or XIX only (including private room days) after 0 11.00 England the cost reporting period (if calendar year, enter 0 on this line) 1.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 England the cost reporting period (if calendar year, enter 0 on this line) 1.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.00 Modical report of swing-bed SNF services applicable to services through December 31 of the cost reporting period (including period (including private room days) 1 10.00 Modical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including the period of the cost applicable to SNF type services through December 31 of the cost reporting period (including the period of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost including the period of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost including the period of the cost applicable to the total period of the cost applicable to the total period of the cost applicable to the type services after December 31 of the cost reporting period (line of the cost including the period of the cost applicable to the total period of the cost reporting period (line of the	10.00		nly (including private s	soom dovo)	440	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days (inclu	10.00			oolii days)	448	10.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 28.592 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 28.592 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 28.590 28.00 General inpatient routine service cost (see instructions) 29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 29.500 Swing-bed cost applicable to NF type services after December 31 of the cost re	11. 00			room days) after	0	11. 00
through December 31 of the cost reporting period 1.00 Mang-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.10 Mang-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.10 Mang-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.10 Mang-bed NF type services applicable to the Program (excluding swing-bed days) 1.10 Mang-bed NF type services applicable to services through December 31 of the cost reporting period days 1.10 Mang-bed NF type services applicable to services after December 31 of the cost reporting period days 1.10 Mang-bed NF type services applicable to services after December 31 of the cost reporting period days 1.10 Mang-bed NF services applicable to services after December 31 of the cost reporting period days 1.10 Mang-bed NF services applicable to services after December 31 of the cost reporting period days 1.10 Mang-bed NF services applicable to services after December 31 of the cost days reporting period days days and the cost reporting period days days and the cost reporting period days days and the cost reporting period days days days days days days days day						
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year) (calendar year) (calendar year) (calendar) (calend	12. 00		X only (including privat	te room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 00 15. 00 Total nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 17. 00 No Mic BED ADJUSTMENT 18. 00 19. 00 No Mic BED ADJUSTMENT 19. 00	13 00		Y only (including privat	te room days)	0	13 00
15.00 Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Senieral inpatient routine service cost harges (excluding swing-bed charges) 31.00 Average perion the combination of the cost reporting period (line 6 6, 273, 563) 32.00 Average perion the combination of the cost reporting period (line 8 6, 273, 563) 33.00 Average perion of the cost cost net of swing-bed cost (line 27 + line 28) 33.00 Average perion of the cost cost net of swing-bed cost (line 27 + line 28)	13.00				O	13.00
10. 00 Nursery days (title V or XIX only) SWING BED ADJUSTIENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting			am (excluding swing-bed	days)	0	
SWING BED ADJUSTMENT 17.00 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 208.70 20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 208.70 20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 208.70 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 2 23.00 x line 18) 23.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 2 23.00 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average peride mprivate room cost differential (line 3 x line 35) 40.00 Average peride mprivate room cost differential (line 3 x line 35) 20.00 Average peride mprivate room cost differential (line 3 x line 35) 20.00 Average peride mprivate room cost differential (line 3 x line 35) 20.00 Average peride mprivate room cost differential (line 3 x line 35) 20.00 Average peride mprivate room cost differential (line 3 x line 35) 30.00 Average peride mprivate room					-	
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20.00 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 208.70 19.00 Proporting period 20.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 208.70 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period 7, 857, 526 21.00 Total general inpatient routine service cost (see instructions) 7, 857, 526 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5	16.00				0	16.00
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 208.70 period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 208.70 period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 28, 592 24.00 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost (see instructions) 29.00 Fivate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 + line 3) 30.00 Average perivate room per diem charge (line 30 + line 4) 30.00 Average perivate room per diem charge (line 30 + line 4) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cost differential (line 3 x line 35) 30.00 Average perivate room cos	17. 00		es through December 31 d	of the cost		17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 208.70 20.00 reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost need to swing-bed cost (line 21 minus line 26) 28. 00 Total swing-bed cost (see instructions) 28. 00 General inpatient routine service cost need to swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Average perivate room per diem charge (line 29 + line 3) 30. 00 Average per diem private room per diem charge (line 30 + line 4) 31. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 32. 00 Average per diem private room cost differential (line 32 minus line 33) 33. 00 Average per diem private room cost differential (line 3 x line 31) 34. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 35. 00 Average meniprivate room cost differential (line 3 x line 31) 35. 00 Average meniprivate room cost differential (line 3 x line 31) 36. 00 Private room cost differential (line 3 x line 35) 37. 00 General inpatient r] 11				
19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 28. 592 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 28. 592 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. 00 Total swing-bed cost (see instructions) 1,583,963 26. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 28, 592 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 28, 592 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 28, 592 24. 00 Swing-bed cost applicable to NF type service safter December 31 of the cost reporting period (line 8 x line 31 25. 00 25. 00 Swing-bed cost applicable to NF type service safter December 31 of the cost reporting peri	18. 00		es after December 31 of	the cost		18.00
reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 29) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost (see instructions) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average peri diem private room per diem charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 31.00 General inpatient routine service cost ret of swing-bed cost and private room cost differential (line 32 minus line 33) 32.00 Average per diem private room cost differential (line 32 x line 35) 33.00 Average per diem private room cost differential (line 32 x line 35) 34.00 Average per diem private room cost differential (line 32 x line 35) 35.00 General inpatient routine service cost (recost per diem (see instructions) 36.00 Proyram general inpatient routine service cost (recost per diem (see instructions) 37.00 Average menus per diem private room cost differential (line 32 x line 3	10.00		s through Docombon 21 of	f the cost	200 70	10.00
20. 00 Medical d'rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of X Iline 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of X Iline 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of X Iline 19) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of X Iline 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of X Iline 20) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROMD DIFFERENTIAL ADJUSTMENT 29. 00 Foreign and the troutine service cost net of swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 20. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 20. 00 Average perioder room per diem charge (line 29 + line 3) 20. 00 Average perioder room per diem charge (line 34 × line 35) 27. 00 Private room cost differential (line 32 x line 35) 28. 00 Average perioder perioder routine service cost net of swing-bed cost and private room cost differential (line 32 x line 35) 29. 00 Private room cost differential adjustment (line 3 x line 35) 20. 00 Average per diem private room charge differential (line 32 x line 35) 20. 01 Average per diem private room charge differential (line 32 x line 35) 20. 02 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 40 x line 34 x line 35) 20. 01 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 40 x line 34 x line 35) 20. 01 General inpatient routine service cost (li	19.00		s through becember 31 of	the cost	206. 70	19.00
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 28.592 24.00 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average per juvate room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Pro	20.00		s after December 31 of t	the cost	208. 70	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 28,592 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 Private room charges (excluding swing-bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perivate room per diem charge (line 29 + line 3) 33.00 Average perivate room per diem charge (line 29 + line 3) 34.00 Average per diem private room cost differential (line 30 x line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 27 minus line 36) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 27 minus line 36) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medi		3				
5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the cost reporting of the cost reporting deriod (line of the cost reporting of the cost reporting of the cost reporting of the cost repor				ting ported (line		
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 * line 3) 30.00 Average per ivate room per diem charge (line 30 * line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per	22.00		er 31 of the cost report	ing period (inte	U	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 28, 592 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost disferential (line 34 x line 31) 30.00 Average per diem private room cost disferential (line 34 x line 31) 30.00 Average per diem private room cost disferential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Add usted general inpatient routine service cost per diem (see instructions) 30.00 Add usted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reportin	ng period (line 6	0	23. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 1,583,963 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6,273,563 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 0.000000 31.00 Average private room per diem charge (line 29 ± line 3) 0.00 32.00 Average semi-private room per diem charge (line 30 ± line 4) 0.00 33.00 Average per diem private room cost differential (line 34 x line 31) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 3, 471.81 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per vate room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3, 982, 166 3, 982, 166 3, 982, 166 3, 980 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		r 31 of the cost reporti	ng period (line	28, 592	24. 00
x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 31.00 Average per diem private room per diem charge (line 30 ÷ line 31) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6, 273, 563 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31. 00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Private room cost differential djustment (line 3 x line 35) 0 36. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37. 00 Program general inpatient routine service cost per diem (see instructions) 3, 471. 81 38. 00 Program general inpatient routine service cost per diem (see instructions) 3, 982, 166 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	20.00		or or the east raper tring	, por ou (11110 0	· ·	20.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 32.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Average per diem pri vate room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 6, 273, 563) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 6, 273, 563) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 3, 982, 166 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 20.00 0 20.00 0 31.00 0 30.00						
28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30	27. 00		(line 21 minus line 26)		6, 273, 563	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28 00		d and observation hed ch	narnes)	0	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 0.00 32.00 0.00 33.00 0.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 Average per diem private room cost differential (line 6, 273, 563) 37.00 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 37.00 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 273, 563) 39.00 Average per diem private room cost differential (line 27 line 38) 39.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 39.00 Average per diem private room cost di			a and observation bed of	idi ges)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00 0.0	30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	÷ line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00 34.00 35.00 36.00 37.00 37.00 37.00 38.00 37.00 38.00 39.00 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nus line 33)(see instru	rtions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 273, 563 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 A 273, 563 37.00 A 273, 563 37.00 A 273, 563 A A 273, 56		, , ,	, ,	1.01.07		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)	•		-	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		and private room cost di	fferential (line	6, 273, 563	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 3, 471.81 38.00 3, 982, 166 40.00 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 3, 471.81 38.00 3, 982, 166 39.00 40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,982,166 39.00 40.00	38. 00				3, 471. 81	38. 00
		,	•			
41. 00 Total Program general impatrent routine service cost (fine 39 + fine 40) 3,982,166 41.00		, , , , , , , , , , , , , , , , , , , ,			-	
	41.00	procar Frogram general impatrent routine service cost (TINE 39	+ IIIIe 40)	l	3, 482, 100	41.00

OMPUT	Financial Systems WAE ATION OF INPATIENT OPERATING COST		Provi der (Peri od:	Worksheet D-1	
				1	From 01/01/2023 To 12/31/2023		pared:
			Titl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.0
00	Intensive Care Type Inpatient Hospital Units		L				1
3. 00	INTENSIVE CARE UNIT						43.0
	CORONARY CARE UNIT						44.0
	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 0 47. 0
. 00	Cost Center Description						47.0
						1. 00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			1, 686, 963	48. C
	Program inpatient cellular therapy acquisiti				column 1)	0	
. 00	Total Program inpatient costs (sum of lines	41 through 48.	01)(see instru	uctions)		5, 669, 129	49.0
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvi cos (fro	om Wket D eur	of Darts L and	0	50. 0
. 00	Pass through costs appricable to Program Trip	atrent routine	services (iii	JIII WKSt. D, Suii	TOT PALLS I ALIC	U	30.0
00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.0
	and IV)		•				
00	Total Program excludable cost (sum of lines	,				0	
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pr	nysician anestr	netist, and	0	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00	Program di scharges					0	54. (
	Target amount per discharge					0. 00	55.
	Permanent adjustment amount per discharge						
	Adjustment amount per discharge (contractor use only)						55.
	Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						56.
00							57.0
00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,						59. (
	updated and compounded by the market basket)	basket)					
00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fr	om prior year	cost report, u	pdated by the	0. 00	60. (
00	<pre>market basket) Continuous improvement bonus payment (if lin</pre>	o EO . Lino E4	ic loce then	the lawest of	Lines EE plus	0	61. (
00	55.01, or line 59, or line 60, enter the les					U	01.0
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)						
	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63. (
00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	na period (See	1, 555, 371	64 (
00	instructions)(title XVIII only)	to till odgi. Doo	o	.o 0001 . opo. 1.	g poi i du (doo	., 555, 57.	
00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	period (See	0	65.
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costo (lino	(4 plug ling	(E) (+; +1 o V)/III	Lonly), for	1 FFF 071	
00	CAH, see instructions	ne costs (iiile	04 prus rine	os)(title xvii	i diliy), i'di	1, 555, 371	66.0
00	Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost re	eporting period	0	67.0
	(line 12 x line 19)						
00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	orting period	0	68.0
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 ± lir	ne 68)		0	69.0
00	PART III - SKILLED NURSING FACILITY, OTHER N						07. (
00	Skilled nursing facility/other nursing facil						70.0
	Adjusted general inpatient routine service c		line 70 ÷ line	2)			71. (
	Program routine service cost (line 9 x line		(1: 14 1	: 25)			72.
	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 74.
00	Capital-related cost allocated to inpatient	•		*	Part II, column		75.0
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ li	,					76.
	Program capital -related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minu		nrovidor soci	-de)			78.
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp		•		nus lina 70)		79. 80.
	Inpatient routine service costs for comp		cost iiiii tali(און פו שווון	ius IIIIc /7)		81.
00	Inpatient routine service cost limitation (1)				82.
00	Reasonable inpatient routine service costs (* .				83.
00	Program inpatient ancillary services (see in						84.
α	Utilization review - physician compensation						85.

205 87.00 3,471.81 88.00

84.00 Program inpatient ancillary services (see instructions)
85.00 Utilization review - physician compensation (see instructions)
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health Financial Systems WAE	BASH GENERAL HOSPITAL DISTRICT In Lieu				u of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST			Period: Worksheet D-1			
		To From		From 01/01/2023 To 12/31/2023		
		Title XVIII Hospital		Cost		
Cost Center Description						
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			711, 721	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	766, 479	7, 857, 526	0. 09754	7 711, 721	69, 426	90.00
91.00 Nursing Program cost	0	7, 857, 526	0.00000	0 711, 721	0	91.00
92.00 Allied health cost	0	7, 857, 526	0.00000	0 711, 721	0	92.00
93.00 All other Medical Education	o	7, 857, 526	0. 00000	0 711, 721	0	93. 00

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1327	Peri od: From 01/01/2023	Worksheet D-1	
				Date/Time Prepared: 5/17/2024 11:02 am	
		Title XIX	Hospi tal	Cost	

		Ti tle XIX	Hospi tal	5/17/2024 11: Cost	02 am
	Cost Center Description	THE XIX	поэрг саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)				1.00
2.00				1, 807	
3. 00	do not complete this line.	ys). If you have only pr	ivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 602	4.00
5.00					5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	o	6.00		
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost		0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	137	7. 00
0.00	reporting period	m daya) aftar Dagambar ()1 of the cost	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	ill days) after beceiliber 3	or the cost		8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	5	9. 00
10.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room davs)	o	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)		
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost		17. 00
10 00	reporting period	oo often December 21 of	+ho ooo+		10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost		18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	208. 70	19. 00
20.00	reporting period			200.70	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after becember 31 of 1	ne cost	208. 70	20.00
21. 00	1 . 9 .	s)		7, 857, 526	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line A	o	23. 00
23.00	x line 18)	or the cost reportin	ig period (iiile c	ĺ	25.00
24. 00] 3	r 31 of the cost reporti	ng period (line	28, 592	24. 00
25 00	7 x line 19)	21 of the cost reporting	norial (line 0	0	25.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (iine 8		25.00
26. 00	Total swing-bed cost (see instructions)			1, 583, 963	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 273, 563	27.00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	narges)	0	28.00
29. 00		d and observation bed er	iai ges)	Ö	1
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	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		•	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost -!	fforontial (!:	4 272 542	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerentiai (IIN6	6, 273, 563	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			3, 471. 81	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		17, 359	1
	Total Program general inpatient routine service cost (line 39				41.00
				'	•

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 14-1327	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/17/2024 11:	epared:
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
3. 00	INTENSIVE CARE UNIT						43.00
4. 00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description			1			17.00
10.00	Decree in the second of the se	-+ D 2I	2 11 200)			1.00	10.00
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			t III line 10	column 1)	25, 247 0	1
	Total Program inpatient costs (sum of lines				, coramir r)	42, 606	
	PASS THROUGH COST ADJUSTMENTS					_	4
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
1. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	from Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	EO and E1)				0	52.00
	Total Program inpatient operating cost exclu		elated. non-ph	nvsician anest	hetist, and	0	1
	medical education costs (line 49 minus line					_]
- 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
	0 Program discharges 0 Target amount per discharge					0. 00	1
						0. 00	
	Adjustment amount per discharge (contractor use only)					0. 00	
	0 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	1
	O Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) O Bonus payment (see instructions)					0	
	00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,					0. 00	59.00
50. 00	updated and compounded by the market basket) OD Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the				0. 00	60.00	
50. 00	market basket)	01 11110 00 111	om prior year	cost roport,	apaarea by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line				61.00		
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	, ,	J	•	, .		
					0	1	
33.00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST					U	03.00
64. 00	00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 0					64.00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of the	cost reportin	a period (See	0	65.00
	instructions)(title XVIII only)				g p (_	
66. 00					0	66.00	
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost r	eportina period	0	67.00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13×1 ine 20)	e costs after l	December 31 of	f the cost rep	orting period	0	68.00
59. 00	Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N						Į
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
	Program routine service cost (line 9 x line		1110 70 - 17116	- -)			72.00
73.00	Medically necessary private room cost applic	able to Program	7	,			73.00
74.00	Total Program general inpatient routine serv			*	Dart II column		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	TOULTHE SELVICE	= costs (110M	worksneet B,	rait II, COIUMN		75.00
	Per diem capital-related costs (line 75 ÷ li	,					76.00
	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi den inecor	-ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	,		•	nus Lino 70)		80.00

Health Financial Systems WAE	BASH GENERAL HO	SPITAL DISTRIC	Г	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		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			711, 721	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	766, 479	7, 857, 526	0. 09754	7 711, 721	69, 426	90.00
91.00 Nursing Program cost	0	7, 857, 526	0.00000	0 711, 721	0	91.00
92.00 Allied health cost	0	7, 857, 526	0.00000	0 711, 721	0	92.00
93.00 All other Medical Education	o	7, 857, 526	0. 00000	0 711, 721	0	93. 00

Health Financial Systems WABASH GENERAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	AL HOSPITAL DISTRICT Provider CC	N: 14-1327	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	
	Title	XVIII	Hospi tal	5/17/2024 11: Cost	02 am
Cost Center Description		Ratio of Cos		Inpati ent	
observation based in per an		To Charges	Program	Program Costs	
		3	Charges	(col. 1 x	
			3	col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 895, 982		30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 20276	1, 794, 896	363, 935	50.00
53. 00 05300 ANESTHESI OLOGY		0. 10487	7 264, 109	27, 699	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13919	98 476, 147	66, 279	54.00
60. 00 06000 LABORATORY		0. 22382	2 874, 895	195, 821	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 55997		114, 004	
65. 01 06501 CARDI AC REHAB		0. 87069	0	0	65. 01
65. 02 06502 PULMONARY		1. 57830	7	11	65.02
65. 03 06503 SLEEP STUDY		0. 27533		0	
66. 00 06600 PHYSI CAL THERAPY		0. 29710		142, 317	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36580		209, 348	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 23767		381, 238	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 23569	787, 383	185, 578	73.00
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC		0. 00000		0	00.00
88.01 08802 RURAL HEALTH CLINIC II		0. 00000		0	88. 01
88. 02 08801 RURAL HEALTH CLINIC III		0.00000		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V		0.00000		0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI		0.00000	-	0	88. 05
90. 00 09000 CLI NI C		1. 28629		14	90.00
90. 01 09001 ORTHOPAEDI C CLI NI C		1. 31445		344	90.01
90. 02 09002 SURGI CAL CLI NI C		2. 50810		105	
90. 03 09003 CARDI OLOGY CLI NI C		1. 04514		227	90.03
90. 04 09004 SENI OR CARE CLI NI C		1. 16443		1	90.04
90. 05 09005 SPECIALTY CLINIC		5. 34184		37	90.05
91. 00 09100 EMERGENCY		0.80413		5	91.00
O Z DO TOO ZOOTERSEDVATION REDS (MONTH STENCT DARI)		1 07,000	Ω 0	Λ.	1 (1) (1)(1)

1. 963899

7, 056, 896

7, 056, 896

95.00

202.00

0 92.00

1, 686, 963 200. 00 201. 00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REI MBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

95. 00 09500 AMBULANCE SERVICES

92.00

200.00

201.00 202.00

Health Financial Systems WABASH GENERAL HOS	_			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	Component		From 01/01/2023 To 12/31/2023		norod.
	Component	CCN: 14-Z327	10 12/31/2023	Date/Time Pre 5/17/2024 11:	nareu: Na am
	Title	XVIII	Swing Beds - SNF		OZ UIII
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
			3	col . 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•			
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 20276	1 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 10487	7 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13919	8 34, 305	4, 775	54.00
60. 00 06000 LABORATORY		0. 22382	2 74, 868	16, 757	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 55997	0 37, 281	20, 876	65.00
65. 01 06501 CARDI AC REHAB		0. 87069	2 0	0	65. 01
65. 02 06502 PULMONARY		1. 57830	4 0	0	65. 02
65. 03 06503 SLEEP STUDY		0. 27533	3 0	0	65.03
66. 00 06600 PHYSI CAL THERAPY		0. 29710	2 362, 495	107, 698	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36580	3 55, 137	20, 169	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 23767	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 23569	0 128, 026	30, 174	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
88.01 08802 RURAL HEALTH CLINIC II		0.00000	0	0	88. 01
88.02 08801 RURAL HEALTH CLINIC III		0.00000	0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0. 00000	0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V		0. 00000	0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI		0. 00000	0	0	88. 05
90. 00 09000 CLI NI C		1. 28629	8 0	0	90.00
90. 01 09001 ORTHOPAEDI C CLI NI C		1. 31445	6 0	0	90. 01
90. 02 09002 SURGI CAL CLI NI C		2. 50810	5 0	0	90. 02
90. 03 09003 CARDI OLOGY CLI NI C		1. 04514	3 0	0	90. 03
90. 04 09004 SENI OR CARE CLI NI C		1. 16443	6 0	0	90. 04
90. 05 09005 SPECIALTY CLINIC		5. 34184	0	0	90. 05
91. 00 09100 EMERGENCY		0. 80413		0	,
OO OO OOOOO ODGEDUATION DEDG (NON DIGTINGT DADT)		4 0/000	٥١	_	1 00 00

0 92.00

200, 449 200. 00

95.00

201.00

202.00

1. 963899

692, 112

692, 112

95. 00 09500 AMBULANCE SERVICES

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems WABASH GE	ENERAL HOSPITAL DISTRICT	-	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
	Titl∈	XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			7, 020		30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 20276		· ·	50.00
53. 00 05300 ANESTHESI OLOGY		0. 10487	·	549	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13919	·	675	54.00
60. 00 06000 LABORATORY		0. 22382	·	715	
65. 00 06500 RESPI RATORY THERAPY		0. 55997		110	
65. 01 06501 CARDI AC REHAB		0. 87069		0	65. 01
65. 02 06502 PULMONARY		1. 57830		0	65. 02
65. 03 06503 SLEEP STUDY		0. 27533		0	65. 03
66. 00 06600 PHYSI CAL THERAPY		0. 29710	·	342	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36580		15, 285	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 23767		0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 23569	0 4, 660	1, 098	73.00
OUTPATIENT SERVICE COST CENTERS			_		
88. 00 08800 RURAL HEALTH CLINIC		1. 39252		0	88. 00
88.01 08802 RURAL HEALTH CLINIC II		1. 48196		0	88. 01
88.02 08801 RURAL HEALTH CLINIC III		1. 71673		0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV		1. 61812		0	88. 03
88.04 08804 RURAL HEALTH CLINIC V		0. 96066	4 0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI		1. 80057		0	88. 05
90. 00 09000 CLI NI C		1. 28629	0 8	0	90.00
90. 01 09001 0RTHOPAEDI C CLI NI C		1. 31445		0	90. 01
90. 02 09002 SURGI CAL CLI NI C		2. 50810	5 0	0	90. 02
90. 03 09003 CARDI OLOGY CLI NI C		1. 04514	3 0	0	90. 03
90. 04 09004 SENI OR CARE CLI NI C		1. 16443		0	90. 04
90. 05 09005 SPECI ALTY CLI NI C		5. 34184		0	90. 05
01 00 00100 EMEDCENCY		0.00/12	1 062	1 407	01 00

0 92.00

25, 247 200. 00

1, 497

91.00

95.00

201.00

202.00

0.804135

1. 963899

1, 862

87, 472

87, 472

91. 00 09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-132	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/17/2024 11:02 am

		Title XVIII	Hospi tal	5/17/2024 11: Cost	02 am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			18, 522, 749	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments	tions)		0	2.00
4. 00	Outlier payment (see instructions)			0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		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 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH dire	ct araduate medical educ	ration costs from	0 0	8. 00 9. 00
7. 00	Wkst. D, Pt. IV, col. 13, line 200	et gradate medicar eddo	Cation Costs II on	0	7.00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			18, 522, 749	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17. 00
	Total customary charges (see instructions)			0	18. 00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		40) (
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	Ty If line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			18, 707, 976	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		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 instruction	6)		147, 806	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	11, 321, 941	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			7, 238, 229	
	instructions)	•			
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
28. 50 29. 00	REH facility payment amount (see instructions)			0	28. 50 29. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			7, 238, 229	
	Primary payer payments			2, 093	
32.00	Subtotal (line 30 minus line 31)			7, 236, 136	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		-	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 778, 848	
	Adjusted reimbursable bad debts (see instructions)			506, 251	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		690, 530	
	Subtotal (see instructions)			7, 742, 387	37.00
	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	39. 00 39. 50
	N95 respirator payment adjustment amount (see instructions)	3)		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
	Subtotal (see instructions)			7, 742, 387	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			154, 848 0	40. 01 40. 02
40. 03	1			· ·	40. 03
41.00	Interim payments			9, 330, 209	41.00
	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-1, 742, 670	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			-1, 142, 070	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	272, 597	44. 00
	§115. 2		·		
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)				93.00
			<u>'</u>		

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1327	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/17/2024 11:	02 am
		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

In Lieu of Form CMS-2552-10 Health Financial Systems WABASH GENERAL HOSPITAL DISTRICT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1327 Peri od: Worksheet E-1 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 4, 874, 072 1.00 Total interim payments paid to provider 8, 665, 840 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 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 12/15/2023 993, 443 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 08/24/2023 384, 179 08/24/2023 329, 074 3.50 50, 659 12/15/2023 3.51 3.51 3.52 0 0 3.52 3 53 0 0 3 53 3.54 3.54 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines -434, 838 664, 369 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 9, 330, 209 4.00 4, 439, 234 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 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) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 5.02 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 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 0 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 823, 141 6.01 6.01 SETTLEMENT TO PROVIDER

1, 742, 670

7, 587, 539

NPR Date

(Mo/Day/Yr)

2.00

5, 262, 375

Contractor

Number

1.00

6.02

7.00

8 00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.02

7.00

 Heal th
 Financial
 Systems
 WABASH G

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 In Lieu of Form CMS-2552-10

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 "MONE" or enter a zero.			'			5/17/2024 11:	02 am
Manual M			Title	XVIII S	wing Beds - SNF	Cost	
1.00			I npati en	t Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered 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 Services Ser				2.00		4. 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 Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered 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 Services Ser	1. 00	Total interim payments paid to provider		1, 330, 752		0	1.00
Services rendered in the cost reporting period. If none, write "NONE" or neter a zero.	2.00					0	2.00
write "NONE" or enter a zero Note to Program ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROGRAM Solution of Lines 3.01-3.49 minus sum of lines 3.35-3.89 Long to the Complete Deprogram Long to Resperately each tentractive sum of lines 1, 2, and 3.99) Long transfer to Wisst. E or Wisst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR LUST separately each tentralive settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider Solution of the interim payments (sum of lines 1, 2, and 3.99) Long transfer to Wisst. E or Wisst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR LUST separately each tentralive settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider Solution of lines 5.01-5.49 minus sum of lines 5.55-59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00		submitted or to be submitted to the contractor for					
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		services rendered in the cost reporting period. If none,					
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) ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 3.06 3.06 3.07 3.07 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00		write "NONE" or enter a zero					
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 3.02 12/15/2023 195,692 0 3.0 3.03 0 0 0 0 3.0 3.04 0 0 0 3.0 3.05 0 0 0 3.0 3.06 0 0 3.0 3.07 0 0 0 3.0 3.07 0 0 0 3.0 3.08 0 0 0 3.0 3.09 Provider to Program 4.00 1 0 0 3.5 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50	3.00	List separately each retroactive lump sum adjustment					3.00
payment. If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provider							
ADJUSTMENTS TO PROVIDER 08/24/2023 195, 692 0 3.0		payment. If none, write "NONE" or enter a zero. (1)					
12/15/2023 29,928 0 3.00 3.		Program to Provider					
3. 03 0.0	3. 01	ADJUSTMENTS TO PROVI DER	08/24/2023	195, 692		0	3. 01
3.04 0 0 0 3.0	3.02		12/15/2023	29, 928	3	0	3.02
ADJUSTMENTS TO PROGRAM	3.03			()	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM	3.04			()	0	3.04
ADJUSTMENTS TO PROGRAM	3.05)	0	3. 05
3.51 0		Provider to Program					
3.52 3.53 3.53 3.53 3.50	3.50	ADJUSTMENTS TO PROGRAM		()	0	3. 50
3.53 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 1, 2, and 3.99) 1,556,372 O	3. 51			()	0	3. 51
3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 225,620	3.52			()	0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.59-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,556,372 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.53			()	0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program Itability (see instructions) Total Medicare program Itabi	3.54			()	0	3. 54
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program Total Me	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		225, 620)	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 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) Program to Provider TENTATIVE TO PROVIDER TENTATIVE TO PROVIDER TO PROGRAM TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TO SUBSTILLEMENT TO PROVIDER TO BETTILLEMENT TO PROVIDER		3. 50-3. 98)					
appropriate To Be COMPLETED BY CONTRACTOR	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 556, 372		0	4.00
TO BE COMPLÉTED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 5.00		(transfer to Wkst. E or Wkst. E-3, line and column as					
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		appropri ate)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider							
TENTATI VE TO PROVI DER							
5.02 0		Program to Provider					
Solution State S	5. 01	TENTATI VE TO PROVI DER		(0	5. 01
Provider to Program	5.02			()	0	5. 02
TENTATIVE TO PROGRAM 0 0 5.50	5. 03			()	0	5. 03
5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) O							
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00	5.50	TENTATI VE TO PROGRAM		()	0	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 171,204 0 6.00 6.02 SETTLEMENT TO PROGRAM 0 0 6.00 7.00 Total Medicare program liability (see instructions) 1,727,576 Contractor Number (Mo/Day/Yr) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 51			()	0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 52			()	0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 171, 204 0 6.00 0 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
7.00 Total Medicare program liability (see instructions)	6. 01			171, 204	·		6. 01
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	6. 02	SETTLEMENT TO PROGRAM		()		6. 02
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		1, 727, 576)		7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1327	Heal th	Financial Systems WABASH GENERAL HOSP	TAL DISTRICT	In Lie	u of Form CMS-	2552-10
To 12/31/2023 Date/Time Prepared: 5/17/2024 11:02 am Title XVIII Hospital Cost To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Inpatient HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/Interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00			Provi der CCN: 14-1327			I
Title XVIII Hospital Cost Title XVIII Hospital Cost					Date/Time Pro	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of			Title XVIII	Hospi tal		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 2.00 Medicare days (see instructions) Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I reasonable cost incurred for the purchase of certi						
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 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 Iine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00						
3.00 4.00 5.00 Total inpatient days (see instructions) 5.00 Total hospital charges from Wkst. S-10, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.0			. S-3, Pt. I col. 15 lin	e 14		
4.00 Total inpatient days (see instructions) Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I in 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)		,				
Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 7.00 8.00 8.00 9.00 1.00 30.00 31.00		, ,				
Iine 168						
9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	7. 00		certified HIT technology	Wkst. S-2, Pt. I		7. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	8.00	Calculation of the HIT incentive payment (see instructions)				8.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 30.00 31.00	9.00					9.00
30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 30.00	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
31.00 Other Adjustment (specify)		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,	,		
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00					31.00	
	32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 14-1327	Peri od: From 01/01/2023	Worksheet E-2

Component CCN: 14-Z327 To 12/31/2023 Date/Time Prepared:

		Component CCN: 14-2327	10 12/31/2023	Date/IIMe Pre 5/17/2024 11:	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
	COMPLITATION OF NET COCT OF COVERED CERVILORS		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		1, 570, 925	0	1.00
2. 00	Inpatient routine services - swing bed-5M (see instructions)		1, 570, 725	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	202, 453	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin				
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4.00
5. 00	instructions) Program days		448	0	5.00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	440	0	
7. 00	Utilization review - physician compensation - SNF optional me	,	0	ū	7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 773, 378	0	8. 00
9. 00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		1, 773, 378	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11. 00
12 00	professional services) Subtotal (line 10 minus line 11)		1, 773, 378	0	12.00
12. 00 13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	10, 600	0	
13.00	for physician professional services)	(excitade corrisarance	10,000	O	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1, 762, 778	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•			16.50
16. 55	Rural community hospital demonstration project (§410A Demonstration project (§410A Demonstration)	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		84	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		55	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructi ons)	84	0	18. 00
19.00	Total (see instructions)		1, 762, 833	0	19. 00
19. 01	Sequestration adjustment (see instructions)		35, 257	0	1
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs			0	19. 03 19. 25
20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		1, 556, 372	0	20.00
20. 01	Interim payments-PARHM		1, 550, 572	O	20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0)	2, 19.25, 20, and 21)	171, 204	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)		_	_	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr	cation) Adiustment			-
200. 00	Is this the first year of the current 5-year demonstration pe				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
202 00	66 (title XVIII hospital))	Wi-+ D 21 2 1:	_		202.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	m WKST. D−3, COL. 3, IIN	e		202. 00
203 UC	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205.00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 to				206. 00
207 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburg				207 00
	Program reimbursement under the §410A Demonstration (see instance) Medicare swing-bed SNF inpatient service costs (from Wkst. E-:	•	1		207. 00 208. 00
200.00	and 3)	z, cor. r, sum or rrites	'		200.00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 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)				I

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/17/2024 11:02 am
	T: +1 - W/111	1 11	C+

	Title XVIII Ho	ospi tal	5/1//2024 11:0 Cost	02 am_
			1 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMI	DIIDSEMENT	1. 00	
1. 00	Inpatient services	JUKSLINLINI	5, 669, 129	1. 00
2. 00	Nursing and Allied Health Managed Care payment (see instructions)		0,007,127	2.00
3. 00	Organ acqui si ti on		o	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)		0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)		5, 669, 129	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5, 725, 820	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
7.00	Reasonable charges			7 00
7. 00 8. 00	Routine service charges		0	7. 00 8. 00
9. 00	Ancillary service charges Organ acquisition charges, net of revenue			9.00
10.00	Total reasonable charges			10.00
10.00	Customary charges		0	10.00
11. 00	Aggregate amount actually collected from patients liable for payment for services on a char	rge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for payment for services on a cl			12.00
	had such payment been made in accordance with 42 CFR 413.13(e)	o .		
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
1/ 00	instructions)	(1/ 00
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) instructions)	(see	0	16. 00
17. 00			o	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)		5, 725, 820	19.00
20.00	Deductibles (exclude professional component)		392, 890	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)		5, 332, 930	
23. 00	Coi nsurance		0	23. 00
24.00	Subtotal (line 22 minus line 23)		5, 332, 930	24.00
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		56, 677	25.00
26. 00 27. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		36, 840 50, 741	26. 00 27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)		5, 369, 770	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		3, 304, 770	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)		o o	29. 50
29. 98	Recovery of accelerated depreciation.		o	29. 98
29. 99	Demonstration payment adjustment amount before sequestration		0	29. 99
30.00	Subtotal (see instructions)		5, 369, 770	30.00
30. 01	Sequestration adjustment (see instructions)		107, 395	30. 01
30. 02	1 1.3 3		0	30. 02
30. 03				30. 03
31.00			4, 439, 234	
31. 01				31.01
32. 00 32. 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0	32. 00 32. 01
32.01	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		823, 141	32.01
33. 00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 3	32 01)	023, 141	33. 00
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter		19, 837	34. 00
	§115. 2	•		

Health Financial Systems WABASH GENERAL BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 14-1327

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			10	12/31/2023	5/17/2024 11:	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS			0.00	.,	
1.00	Cash on hand in banks	10, 147, 769		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	23, 547, 466	0	0	0	2. 00 3. 00
4. 00	Accounts recei vable	38, 412, 129		0	0	4.00
5. 00	Other recei vable	62, 424		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23, 769, 942		0	0	6.00
7.00	Inventory	1, 393, 065	0	0	0	7. 00
8. 00	Prepai d expenses	1 2// 145		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	1, 366, 145		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	51, 159, 056	1	0	0	11.00
	FIXED ASSETS	, , , , , , , , , , , , , , , , , , , ,	*			
12.00	Land	972, 752		0	0	12.00
13.00	Land improvements	2, 527, 748		0	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-1, 467, 627 46, 214, 004	1	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-15, 842, 726	1	0	0	16.00
17. 00	Leasehold improvements	0	o o	0	0	17.00
18.00	Accumul ated depreciation	-2, 673, 441	0	0	0	18.00
19.00	Fixed equipment	4, 373, 211		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-5, 216, 891		0	0	20.00
22. 00	Accumulated depreciation	0		0	0	21.00
23. 00	Maj or movable equipment	16, 068, 175		0	0	23.00
24.00	Accumul ated depreciation	800, 498	1	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		0	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	45, 755, 703		0	0	30.00
	OTHER ASSETS					
31.00	Investments	0		0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	0		0	0	32. 00 33. 00
34.00	Other assets	Ö		Ö	Ö	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	96, 914, 759	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	2, 080, 932	2 0	0	0	37.00
38. 00	Salaries, wages, and fees payable	19, 074, 220	I	0	0	38.00
39. 00	Payrol I taxes payable	0	o	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	34, 767	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	2, 679, 509		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	23, 869, 428		0		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47. 00 48. 00	Notes payable Unsecured Loans	1, 955, 000		0	0	47. 00 48. 00
49.00	Other long term liabilities	0		0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 955, 000		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25, 824, 428	0	0	0	51.00
F0 00	CAPITAL ACCOUNTS	74 000 004				
52. 00 53. 00	General fund balance Specific purpose fund	71, 090, 331	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	71, 090, 331	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	96, 914, 759		0	0	60.00
	[59]					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES | Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-1327

					To 12/31/2023	Date/Time Pre 5/17/2024 11:	
		Genera	l Fund	Special P	urpose Fund	Endowment Fund	
						Tunu	
		1. 00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		62, 017, 848		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9, 072, 482				2.00
3.00	Total (sum of line 1 and line 2)	_	71, 090, 330		0	l	3.00
4.00	ROUDNI NG	1				0	
5. 00 6. 00		0				0	
7. 00		0		1			
8. 00		0				0	
9. 00		0				Ö	1
10.00	Total additions (sum of line 4-9)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		71, 090, 331		0		11.00
12.00	Deductions (debit adjustments) (specify)	0			D	0	
13.00		0			O O	0	
14.00		0		9		0	
15. 00 16. 00		0				0	
17. 00		0					
18. 00	Total deductions (sum of lines 12-17)		0	,	0	0	18.00
19. 00	Fund balance at end of period per balance		71, 090, 331		0		19.00
	sheet (line 11 minus line 18)		,				
		Endowment	PI ant	Fund			
		Fund		Γ	_		
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(D		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)	O	0		ס		3.00
4. 00 5. 00	ROUDNI NG		0				4. 00 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		(D		10.00
11. 00	Subtotal (line 3 plus line 10)	0		(D		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14. 00 15. 00			0				14. 00 15. 00
16.00			0				16.00
17. 00			0				17.00
18. 00	Total deductions (sum of lines 12-17)	0			o		18.00
19. 00	Fund balance at end of period per balance	0					19.00
	sheet (line 11 minus line 18)						

Date/Time Prepared: 12/31/2023 5/17/2024 11:02 am Cost Center Description Inpati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 4,009,393 4, 009, 393 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 6.00 0 SKILLED NURSING FACILITY 7.00 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) 4, 009, 393 4,009,393 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16.00 0 0 16,00 11 - 15) 17.00 4,009,393 4,009,393 17 00 Total inpatient routine care services (sum of lines 10 and 16) Ancillary services 12, 887, 024 144, 957, 130 157, 844, 154 18.00 18.00 Outpatient services 27, 095, 560 27, 095, 560 19.00 0 19.00 RURAL HEALTH CLINIC 0 494.454 494, 454 20.00 20.00 20.01 RURAL HEALTH CLINIC II 2, 423, 034 2, 423, 034 20.01 20.02 RURAL HEALTH CLINIC III 0 958, 969 958, 969 20.02 RURAL HEALTH CLINIC IV 1, 090, 473 1, 090, 473 0 20.03 20.03 20.04 RURAL HEALTH CLINIC V 0 1, 425, 046 1, 425, 046 20.04 20.05 RURAL HEALTH CLINIC VI 0 603, 581 603, 581 20.05 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 HOME HEALTH AGENCY 22.00 22.00 0 23.00 AMBULANCE SERVICES 2, 755, 514 2, 755, 514 23.00 24.00 CMHC 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 HOSPI CE 26,00 26.00 27.00 OTHER (SPECIFY) 0 27.00 16, 896, 417 198, 700, 178 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 181, 803, 761 28.00 G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 80, 417, 740 29.00 30.00 ADD (SPECIFY) 30.00 31.00 0 31.00 0 32.00 32 00 33.00 33.00 34.00 0 34.00 0 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 0 38.00 0 39.00 39.00 0 40.00 40.00 41.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 80, 417, 740 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 43.00

Provider CCN: 14-1327

Peri od:

From 01/01/2023

to Wkst. G-3, line 4)

Hoal th	Financial Systems WABASH GENERAL HOSP	ITAL DISTRICT	In Lio	u of Form CMS-2	2552 10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 14-1327	Peri od:	Worksheet G-3	
			From 01/01/2023		
			To 12/31/2023		
				5/17/2024 11:	02 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lii	20, 20)		198, 700, 178	1.00
2. 00	Less contractual allowances and discounts on patients' accounts			112, 727, 007	
3. 00	Net patient revenues (line 1 minus line 2)	11.5		85, 973, 171	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	12)		80, 417, 740	ł
5. 00					
3.00	OTHER I NCOME			5, 555, 431	5.00
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			992, 865	
8. 00	Revenues from telephone and other miscellaneous communication	n services		772,000	1
9. 00	Revenue from television and radio service	1 301 11 003		0	9.00
	Purchase di scounts			4, 769	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			254, 753	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		1, 764	•
	Revenue from sale of drugs to other than patients	•		0	17.00
	Revenue from sale of medical records and abstracts			13, 028	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	1
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
				_	l

21.00

22.00

23.00

25.00

26.00

27.00

58, 700

3, 528, 603

9, 084, 034

11, 552

11, 552 28. 00 9, 072, 482 29. 00

0

0 24.50

21.00 Rental of vending machines

23.00 Governmental appropriations

26.00 Total (line 5 plus line 25)

27. 00 NONOPERATING GAINS LOSSES

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)

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)

22.00 Rental of hospital space

24.00 OTHER OPERATING INCOME

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
ANALYCIC OF HOCDITAL DACED DUCKEOUS COSTS		D: -I CCN 14 1227	Davet and	Wasalsalaaa M. 1

Heal th	Financial Systems WAB	ASH GENERAL HOS	SPITAL DISTRIC	Т	In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 Fo 12/31/2023		
					RHC I	Cost	OZ alli
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat		
		'		+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS		405 700	105 70		105 700	1 00
1.00	Physician Assistant	0	125, 798				1. 00 2. 00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0	0		16, 695 1, 350		
4. 00	Visiting Nurse	0	0		0 1, 350		4.00
5. 00	Other Nurse	0	0		79, 071		5.00
6. 00	Clinical Psychologist	0	0		77,071	74,071	6.00
7. 00	Clinical Social Worker	0	0				7.00
7. 10	Marriage and Family Therapist		O	· `		· ·	7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	125, 798	125, 798	97, 116	222, 914	10.00
11.00	Physician Services Under Agreement	0	0	(0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	(0	0	12.00
13.00	Other Costs Under Agreement	0	0	(0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15. 00	Medical Supplies	0	6, 342	6, 342	2 0	6, 342	
16. 00	Transportation (Health Care Staff)	0	0	(0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17.00
18. 00	Professional Liability Insurance	0	0	(0	0	18.00
19.00	Other Health Care Costs	0	0	(0	0	19.00
20.00	Allowable GME Costs		(242	(24		(242	20.00
21. 00 22. 00	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	0	6, 342 132, 140			6, 342 229, 256	
22.00	lines 10, 14, and 21)	U	132, 140	132, 140	97, 110	229, 230	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			l		L	
23. 00	Pharmacy	0	0		0	0	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0	(0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25.02	Chronic Care Management	0	0	(0	0	25. 02
26.00	All other nonreimbursable costs	0	0	(0	0	26.00
27. 00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	(0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD		4 007	1 00	7	1 207	20.00
29.00	Facility Costs	0 105, 063	1, 307 15, 888			,	29.00
30. 00 31. 00	Administrative Costs Total Facility Overhead (sum of lines 29 and		15, 888		· ·		
31.00	30)	100,003	17, 195	122, 230	-91, 115	25, 143	31.00
32. 00	Total facility costs (sum of lines 22, 28	105, 063	149, 335	254, 398	3 1	254, 399	32. 00
52.00	and 31)	100,000	117,000	201, 37	'	201,077	52.00
	1	'		'	1	'	•

			Component	CCN: 14-8501	To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC I	Cost	OZ dili
		Adjustments	Net Expenses				
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS		405 700				
1.00	Physi ci an	0	125, 798				1.00
2.00	Physician Assistant	54, 824	71, 519				2.00
3.00	Nurse Practitioner	0	1, 350	1			3.00
4. 00 5. 00	Visiting Nurse Other Nurse	0	79, 071	1			4. 00 5. 00
6. 00	Clinical Psychologist	0	79, 07 i	1			6.00
7. 00	Clinical Social Worker	0	C	1			7.00
7. 10	Marriage and Family Therapist	o _l	C	ή			7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	C				8.00
9. 00	Other Facility Health Care Staff Costs	0	C	•			9.00
10.00	Subtotal (sum of lines 1 through 9)	54, 824	277, 738	8			10.00
11.00	Physician Services Under Agreement	0	C	1			11.00
12.00	Physician Supervision Under Agreement	0	C				12.00
13.00	Other Costs Under Agreement	0	C				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C				14.00
15.00	Medical Supplies	0	6, 342	2			15.00
16. 00	Transportation (Health Care Staff)	0	C)			16.00
17. 00	Depreciation-Medical Equipment	0	C	1			17.00
18. 00	Professional Liability Insurance	0	C	•			18. 00
19. 00	Other Health Care Costs	0	C)			19. 00
20.00	Allowable GME Costs	_					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	6, 342				21.00
22. 00	Total Cost of Health Care Services (sum of	54, 824	284, 080)			22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy	ol	C	N .			23. 00
24. 00	Dental	0	C	1			24.00
25. 00	Optometry	0	C	1			25. 00
25. 01	Tel eheal th	0	C	1			25. 01
25. 02	Chronic Care Management	0	C	•			25. 02
26. 00	All other nonreimbursable costs	o	C				26.00
27. 00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	C				28.00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	1, 055	2, 362	2			29. 00
30.00	Administrative Costs	0	23, 836	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	1, 055	26, 198	3			31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	55, 879	310, 278	3			32.00
	and 31)			I			I

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL PASED DUS (FOUS COSTS	Direction - CON 14 1227	David and Ward about M 1

Heal th	Financial Systems WAE	SASH GENERAL HOS	SPITAL DISTRIC	T	In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC II	Cost	UZ alli
		Compensation	Other Costs	Total (col	1 Reclassificat		
		Compensation	011101 00313	+ col . 2)	ions	Tri al Balance	
				1 001. 2)	1 0115	(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 1, 172, 081	1, 172, 081	1.00
2.00	Physici an Assistant	o	0		0 276, 110		2.00
3.00	Nurse Practitioner	o	0		0 140, 446	140, 446	3.00
4.00	Visiting Nurse	o	0		0 0	0	4.00
5.00	Other Nurse	o	0		0 300, 479	300, 479	5.00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7.00	Clinical Social Worker	o	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	o	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	o	0		0 356, 514	356, 514	9.00
10.00	Subtotal (sum of lines 1 through 9)	o	0		0 2, 245, 630	2, 245, 630	10.00
11.00	Physician Services Under Agreement	o	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	60, 661	60, 66	1 0	60, 661	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60, 661		1 0	60, 661	21.00
22.00	Total Cost of Health Care Services (sum of	0	60, 661	60, 66	2, 245, 630	2, 306, 291	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	24.00
25. 00	Optometry	0	0		0	0	25.00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonallowable GME costs	_	_			_	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD		2 002	2.00	12	2 002	20.00
29. 00	Facility Costs	0	3, 892	•		3, 892	29.00
30.00	Administrative Costs	2, 346, 560	395, 259			l	30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	2, 346, 560	399, 151	2, 745, 71	1 -2, 245, 630	500, 081	31.00
32. 00	Total facility costs (sum of lines 22, 28	2, 346, 560	459, 812	2, 806, 37	2 0	2, 806, 372	32. 00
3Z. UU	and 31)	2, 340, 300	407,012	2,000,37	2	2,000,372	JZ. 00
	14.14 5.7	ı l		ı	1	ı	ı

Health Financial Systems WABASH GENERA	AL HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-1327	
		From 01/01/2023

Adjustments					Component	CCN: 14-8568	To 12/31/2023	Date/Time Pro 5/17/2024 11:	
FACILITY HEALTH CARE STAFF COSTS							RHC II		
Allocation (col. 5 + col. 6) Col. 5 + col. 6 C		·	Adjustments	Net	Expenses				
Col. 5 + Col. 6 C					for				
FACILITY HEALTH CARE STAFF COSTS				ΑI	I ocati on				
FACILITY HEALTH CARE STAFF COSTS 1, 439 1,173,520 1, 00 2, 00 2, 0				((col. 5 +				
FACILITY HEALTH CARE STAFF COSTS				(col. 6)				
1.00			6. 00		7. 00				
2.00									4
3.00 Nurse Practitioner			1, 439			1			1
4.00 Visiting Nurse			٦			•			1
5.00		4	0			1			1
Color Colo			0			1			1
7.00		4	0			. 1			
7. 10			0		_	1			
7.11		1	0		C)			1
B. 00		, ,							1
9.00 Other Facility Health Care Staff Costs 0 356,514 0.00 Subtotal (sum of lines 1 through 9) 1,439 2,247,069 10.00 11.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 16.00 17.00 17.		·			_				1
10.00 Subtotal (sum of lines 1 through 9) 1,439 2,247,069 10.00			0		_				
11.00 Physician Services Under Agreement 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00			1 120						1
12.00		` ,	1, 439			1			
13.00 Other Costs Under Agreement 0 0 0 14.00 14.00 14.00 15.00 Medical Supplies 0 0 0 0 14.00 15.00 Medical Supplies 0 0 0 0 0 15.00 16.00 Transportation (Heal th Care Staff) 0 0 0 0 0 17.00 0 0 0 0 0 0 0 0 0			0			1			1
14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 20. 00 21. 00 21. 00 21. 00 21. 00 21. 00 21. 00 22. 00 21. 00 22. 00 21. 00 22. 00 21. 00 22. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 21. 00 22. 00 24. 00 25. 01 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 01 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 01 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20			U O		_				1
15. 00 Medical Supplies		3	0		_				
16. 00 Transportation (Heal th Care Staff) 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 17. 00 18. 00 17. 00 18. 00 19. 00 0 19. 00 0 0 19. 00 0 19. 00 0 19. 00 0 19. 00 0 19. 00 0 19. 00 0 19. 00 0 19. 00 1			0						1
17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 19. 00 19. 00 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 0 0 0 0 0 0 0			0		•	1			
18.00 Professional Liability Insurance 0 0 0 0 0 19.00 0 19.00 0 0 0 0 0 0 0 0 0			0						1
19. 00 Other Health Care Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0			1			1
20.00 Allowable GME Costs 21.00 Subtotal (sum of lines 15 through 20) 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 24.00 Dental 0 0 0 25.00 Optometry 0 0 0 25.01 Tel eheal th 0 0 0 25.02 Chronic Care Management 26.00 All other nonreimbursable costs 0 Nonal lowable GME costs 0 Nonal lowable GME costs 0 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29.00 Administrative Costs 0 Total Facility Overhead (sum of lines 29 and 30.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00		1	0			1			
21.00 Subtotal (sum of lines 15 through 20) 0 60,661 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 2,307,730 22.00 22.00 23.00 24.00 25.00 24.00 25.00 26.00 25.00 26.00 2		4	Ĭ			1			1
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Optometry Optome		4	0		60 661	1			
Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			1, 439			1			1
COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy Dental O O O O O O O O O			.,		_,,				
24.00 Dental 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.01 Tel eheal th 0 0 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 0 27.00 Nonall owable GME costs 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						<u>'</u>			1
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 25. 01 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 26. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 4 Costs 27. 00 Pacific P	23.00	Pharmacy	0		C				23. 00
25. 01 Telehealth 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24.00	Dental	o		C				24.00
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0		C				25.00
26.00	25. 01	Tel eheal th	0		C				25. 01
27. 00 28. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) Total Facility Costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 27. 00 28. 00 28. 00 28. 00 28. 00 29. 00 29. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 32. 00	25. 02	Chronic Care Management	0		C				25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4	0		C)			
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 1.00 Total Facility Overhead (sum of lines 29 and 30.00 31.00 30.00 30.00 30.00 31.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00 32.00		Nonallowable GME costs							27. 00
FACILITY OVERHEAD 29.00 Facility Costs	28. 00		0		C)			28. 00
29.00 Facility Costs 25,701 29,593 29.00 30.00 Administrative Costs 0 496,189 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 27,140 2,833,512 32.00									1
30.00 Administrative Costs 0 496, 189 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 7 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00 30.00									4
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 31.00			25, 701			•			
30) 32.00 Total facility costs (sum of lines 22, 28 27,140 2,833,512 32.00		4	0			1			1
32.00 Total facility costs (sum of lines 22, 28 27, 140 2, 833, 512 32.00	31.00		25, 701		525, 782	<u>'</u>			31.00
	22 00	1 - 7	27 140		2 022 542				22.00
	32.00		27, 140		∠, ʊɔɔ, ɔ1∠	-			32.00
		juna 51)	I			1			I

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT		In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL_BASED RHC/FOHC COSTS		Provider CCN: 14-1327	Peri od:	Worksheet M_1

Heal th	Financial Systems WAE	SASH GENERAL HOS	SPITAL DISTRIC	T	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			C		From 01/01/2023	D-+- /T: D	
			Component	CCN: 14-8579	Го 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC III	Cost	<u> </u>
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1			
1.00	Physi ci an	0	0			556, 461	1.00
2.00	Physician Assistant	0	0			123, 229	2.00
3.00	Nurse Practitioner	0	0	1		0	3. 00 4. 00
4. 00 5. 00	Visiting Nurse Other Nurse	0	0)	67, 082	67, 082	5.00
6. 00	Clinical Psychologist		0)	07,002	07,082	6.00
7. 00	Clinical Social Worker		0			0	7.00
7. 10	Marriage and Family Therapist	١	O	`			7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		-	257, 651	9.00
10.00	Subtotal (sum of lines 1 through 9)	ol	0		1, 004, 423	1, 004, 423	1
11. 00	Physician Services Under Agreement	o	0			0	11.00
12.00	Physician Supervision Under Agreement	o	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0		0	0	14.00
15.00	Medical Supplies	o	30, 682	30, 682	2 0	30, 682	15.00
16.00	Transportation (Health Care Staff)	0	0	(0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	(0	0	17. 00
18. 00	Professional Liability Insurance	0	0	(0	0	18. 00
19. 00	Other Health Care Costs	0	0	(0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	30, 682			30, 682	21.00
22. 00	Total Cost of Health Care Services (sum of	0	30, 682	30, 682	1, 004, 423	1, 035, 105	22. 00
	lines 10, 14, and 21)						
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	ol	0	1 ,	0	0	23. 00
24. 00	Dental		0			0	24.00
25. 00	Optometry		0		-	0	25.00
25. 00	Tel eheal th		0			0	25. 00
25. 01	Chronic Care Management		0			0	25. 01
26. 00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonallowable GME costs		O	`			27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28.00
20.00	through 27)	Ĭ	· ·	`		Ŭ	20.00
	FACILITY OVERHEAD	'		<u>'</u>	<u>'</u>		ĺ
29.00	Facility Costs	0	10, 257	10, 25	7 0	10, 257	29. 00
30.00	Administrative Costs	1, 005, 896	189, 362			190, 835	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	1, 005, 896	199, 619	1, 205, 51	-1, 004, 423	201, 092	31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	1, 005, 896	230, 301	1, 236, 19	7 0	1, 236, 197	32.00
	and 31)			l			

Health Financial Systems WA	BASH GENERAL HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1327	
		From 01/01/2023

				Component	CCN: 14-8579	To 12/31/2023	Date/Time Pro 5/17/2024 11:	
						RHC III	Cost	
		Adjustments	Net	Expenses				
				for				
			ΑI	I ocati on				
			•	col. 5 +				
				col. 6)				
		6. 00		7. 00				
	FACILITY HEALTH CARE STAFF COSTS							1
1. 00	Physi ci an	0		556, 461				1.00
2. 00	Physician Assistant	0		123, 229	1			2.00
3.00	Nurse Practitioner	0		C	1			3.00
4.00	Visiting Nurse	0		(7,000	1			4.00
5.00	Other Nurse	0		67, 082	1			5.00
6.00	Clinical Psychologist	0		C	1			6.00
7.00	Clinical Social Worker	o _l		C	'			7.00
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor	0		_				7. 11 8. 00
8. 00 9. 00	Laboratory Technician Other Facility Health Care Staff Costs	0		257, 651	1			9.00
10.00	Subtotal (sum of lines 1 through 9)	0		1, 004, 423				10.00
11. 00	`	0		1,004,423	1			11. 00
12. 00	3	0		0	1			12.00
13. 00		0		(1			13.00
14. 00	3	0		0	1			14. 00
15. 00	, , , , , , , , , , , , , , , , , , , ,	0		30, 682	1			15. 00
16. 00				30, 002	1			16.00
17. 00	, , , , , , , , , , , , , , , , , , , ,	0		C	1			17. 00
18. 00	1 .	0			1			18.00
19. 00	1	o		Ċ				19.00
20. 00	1	٦						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		30, 682				21.00
22. 00	Total Cost of Health Care Services (sum of	ol		1, 035, 105				22.00
	lines 10, 14, and 21)			, ,				
	COSTS OTHER THAN RHC/FQHC SERVICES				•			
23.00	Pharmacy	0		C				23. 00
24.00	Dental	0		C)			24.00
25.00	Optometry	0		C)			25. 00
25. 01	Tel eheal th	0		C)			25. 01
25. 02	Chronic Care Management	0		C)			25. 02
26. 00		0		C)			26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		C)			28. 00
	through 27)							1
20.00	FACILITY OVERHEAD	<u></u>		10.05	,			20.00
	Facility Costs	7 022		10, 257				29.00
30.00		-7, 833		183, 002	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	-7, 833		193, 259	Ί			31.00
32. 00	1 /	-7, 833		1, 228, 364	1			32.00
JZ. UU	and 31)	-1,033		1, 220, 304	1			32.00
	10.00	ı			1			1

Health Financial Systems WABASH GENERAL HOSPIT		TAL DISTRICT	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL BASED BUC/FOUR COSTS		Provi don CCN: 14 1227	Pori od:	Workshoot M 1

Heal th	Financial Systems WAE	BASH GENERAL HOS	SPITAL DISTRIC	T	In Lie	u of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1327	Peri od:	Worksheet M-1	
					From 01/01/2023	5	
			Component	CCN: 14-8599	To 12/31/2023	Date/Time Pre 5/17/2024 11:	pared:
					RHC IV	Cost	UZ alli
		Compensation	Other Costs	Total (col	1 Reclassi fi cat	Recl assi fi ed	
		oomponoa er on	011101 00010	+ col . 2)	ions	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	0	0	1	0 281, 900	· ·	1.00
2.00	Physici an Assistant	0	0	1	0 390, 813	390, 813	2.00
3. 00	Nurse Practitioner	0	0		0 116, 809	116, 809	3.00
4.00	Visiting Nurse	0	0	1	0	0	4. 00
5. 00	Other Nurse	0	0	1	0 163, 442	163, 442	5. 00
6. 00	Clinical Psychologist	0	0	1	0	0	6.00
7. 00	Clinical Social Worker	0	0	1	0	0	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Technician	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0 0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	0	0	1	0 952, 964	952, 964	
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12. 00 13. 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	0		0	0	14.00
15. 00	Medical Supplies	0	33, 910	33, 91	0	33, 910	
16. 00	Transportation (Health Care Staff)	0	33, 710	33, 7	0	33, 410	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	Other Health Care Costs	0	0		0 0	, o	19.00
20. 00	Allowable GME Costs		· ·				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	33, 910	33, 91	0 0	33, 910	
22. 00	Total Cost of Health Care Services (sum of	o	33, 910			986, 874	
	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 0	0	25. 01
25. 02	Chronic Care Management	0	0)	0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0)	0	0	26. 00
27. 00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD				1		
29. 00	Facility Costs	0	14, 690			14, 690	
30.00	Administrative Costs	1, 095, 580	228, 202				
31. 00	Total Facility Overhead (sum of lines 29 and	1, 095, 580	242, 892	1, 338, 47	-952, 964	385, 508	31.00
32. 00	30) Total facility costs (sum of lines 22, 28	1, 095, 580	276, 802	1, 372, 38	22	1, 372, 382	32.00
32.00	and 31)	1,090,080	270,802	1,3/2,36	0	1,3/2,382	32.00
	Tana 01)	ı I		1	T .	ı	ı

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1327	
	0	From 01/01/2023

			C	Component	CCN: 14-859	9	To 12/31/2023	Date/Time Pr 5/17/2024 11	epared:
							RHC IV	Cost	. 02 4111
		Adjustments	Net	Expenses			100 1 0	0031	
		riaj astilierres	1101	for					
			ΔΙΙ	ocati on					
				ol . 5 +					
			•	ol. 6)					
		6. 00		7.00	-				
	FACILITY HEALTH CARE STAFF COSTS	0.00		7.00					
1. 00	Physi ci an	0		281, 900	וו				1.00
2. 00	Physician Assistant	-54, 825		335, 988					2.00
3. 00	Nurse Practitioner	01,020		116, 809					3.00
4. 00	Visiting Nurse	Ö		(110,00	1				4.00
5. 00	Other Nurse	0		163, 442	-1				5.00
6. 00	Clinical Psychologist	0		105, 442	1				6.00
7. 00	Clinical Social Worker	0							7.00
7. 10	Marriage and Family Therapist	٥		,	7				7. 10
7. 10	Mental Health Counselor								7. 10
8. 00	Laboratory Techni ci an	0		,					8.00
9. 00	Other Facility Health Care Staff Costs	0							9.00
10.00		E4 02E			-1				10.00
	Subtotal (sum of lines 1 through 9)	-54, 825		898, 139	•				
	Physician Services Under Agreement	0		(11.00
	Physician Supervision Under Agreement	0		(- 1				12.00
	Other Costs Under Agreement	0		(-1				13.00
	Subtotal (sum of lines 11 through 13)	0			2				14.00
	Medical Supplies	0		33, 910)				15.00
	Transportation (Health Care Staff)	0		()				16.00
	Depreciation-Medical Equipment	0			0				17.00
	Professional Liability Insurance	0		(-1				18.00
	Other Health Care Costs	O		(ار				19.00
	Allowable GME Costs								20.00
	Subtotal (sum of lines 15 through 20)	- 0		33, 910					21.00
22. 00	Total Cost of Health Care Services (sum of	-54, 825		932, 049	7				22. 00
	lines 10, 14, and 21)								
00.00	COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	Pharmacy	0			0				23.00
24. 00	Dental	0			0				24.00
25. 00	Optometry	0		(-				25.00
	Tel eheal th	0			0				25. 01
25. 02	Chronic Care Management	0			0				25. 02
26. 00	All other nonreimbursable costs	0		()				26.00
27. 00	Nonallowable GME costs	_			_				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		()				28. 00
	through 27)								_
20.00	FACILITY OVERHEAD	/4 405		7/ 141	-				20.00
	Facility Costs	61, 425		76, 115					29.00
30.00	Administrative Costs	-7, 681		363, 137	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	53, 744		439, 252	4				31.00
22.00	30)	1 001		1 271 20	,				22.00
32. 00	Total facility costs (sum of lines 22, 28	-1, 081		1, 371, 30	'				32.00
	and 31)				1				1

Health Financial Systems	WABASH GENERAL HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
ANALYCIC OF HOCDITAL BACED DUC/FOLIC COCTC	Diani da CON 14 1227	David and Wardingham M. 1

Heal th	Financial Systems WAE	BASH GENERAL HOS	SPITAL DISTRIC	T	In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1327	Peri od:	Worksheet M-1	
					From 01/01/2023		
			Component	CCN: 14-8601	To 12/31/2023	Date/Time Pre	pared:
					DUO V	5/17/2024 11:	02 am_
				I 	RHC V	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Reclassi fied	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1			
1. 00	Physi ci an	0	0		0 190, 554	190, 554	1.00
2.00	Physici an Assistant	0	0	1	0 9, 872	9, 872	2.00
3.00	Nurse Practitioner	0	0	1	0 105, 558	105, 558	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0)	0 183, 540	183, 540	5.00
6.00	Clinical Psychologist	0	0)	0	0	6.00
7.00	Clinical Social Worker	o	0)	0 0	0	7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Technician	0	0		0 21, 650	21, 650	8.00
9. 00	Other Facility Health Care Staff Costs	o o	0		0 81, 108	81, 108	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0		0 592, 282	592, 282	10.00
11. 00	Physician Services Under Agreement	0	0		0 372, 202	0	11.00
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
	9	0	0	1	0	_	
14.00	Subtotal (sum of lines 11 through 13)	0	00.070	00.0	0	0	14.00
15.00	Medical Supplies	0	28, 078	28, 0		28, 078	
16. 00	Transportation (Health Care Staff)	0	0	1	0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17. 00
18. 00	Professional Liability Insurance	0	0	1	0	0	18. 00
19. 00	Other Health Care Costs	0	0)	0	0	19. 00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28, 078	28, 0	78 0	28, 078	21.00
22.00	Total Cost of Health Care Services (sum of	0	28, 078	28, 0	78 592, 282	620, 360	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	o	0	1	0 0	0	24.00
25.00	Optometry	0	0)	0 0	0	25. 00
25. 01	Tel eheal th	ol	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs	J	· ·			Ü	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28.00
20.00	through 27)	U	U		0	U	20.00
	FACILITY OVERHEAD						
20.00		ol	10 500	19, 5	20	19, 588	29.00
29. 00	Facility Costs		19, 588				
30.00	Administrative Costs	718, 051	298, 338			424, 107	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	718, 051	317, 926	1, 035, 9	-592, 282	443, 695	31.00
00.05	30)	740 0= :	o.,	1		4 0/ 4 0==	00.05
32. 00	Total facility costs (sum of lines 22, 28	718, 051	346, 004	1, 064, 0	0	1, 064, 055	32.00
	and 31)			1	1		l

			Component	CCN: 14-8601	To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC V	Cost	
		Adjustments	Net Expenses				
		, i	for				
			Allocation				
			(col. 5 +				
			col . 6)				
		6. 00	7.00	1			
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	190, 554	1			1.00
2.00	Physician Assistant	O	9, 872	2			2.00
3.00	Nurse Practitioner	o	105, 558	3			3.00
4.00	Visiting Nurse	O	C				4.00
5.00	Other Nurse	0	183, 540	ol			5.00
6.00	Clinical Psychologist	o		1			6.00
7. 00	Clinical Social Worker	0	Ċ				7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	21, 650				8.00
9. 00	Other Facility Health Care Staff Costs	0	81, 108				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	592, 282				10.00
11. 00	Physician Services Under Agreement	Ö	072, 202	1			11.00
12. 00	Physician Supervision Under Agreement	o o	C				12.00
13. 00	Other Costs Under Agreement	0	C	- 1			13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	C	1			14. 00
15. 00	Medical Supplies	0	28, 078	1			15. 00
16. 00	Transportation (Health Care Staff)	0	20, 070	1			16.00
17. 00	Depreciation-Medical Equipment	0	C	1			17. 00
18. 00	Professional Liability Insurance	0	C				18.00
19. 00	Other Health Care Costs	0		1			19.00
20.00	Allowable GME Costs	o o		1			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28, 078				21.00
22. 00	Total Cost of Health Care Services (sum of	0	620, 360	1			22.00
22.00	lines 10, 14, and 21)	o o	020, 300	1			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy Pharmacy	0	C				23. 00
24. 00	Dental	Ö	C				24.00
25. 00	Optometry	o	C	- 1			25. 00
25. 01	Tel eheal th	0	Č				25. 01
25. 02	Chronic Care Management	Ö	C				25. 02
26. 00	All other nonreimbursable costs	Ö	C	- 1			26.00
27. 00	Nonallowable GME costs	Ĭ		1			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C				28. 00
20.00	through 27)			1			20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	54, 104	73, 692				29. 00
30.00	Administrative Costs	-17, 814	406, 293	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	36, 290	479, 985				31.00
500	30)	33, 270	1,7,700				000
32. 00	Total facility costs (sum of lines 22, 28	36, 290	1, 100, 345	5			32.00
	and 31)	, -, 0	.,, 0 10				
		1		•			•

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	of Form CMS-2552-10
ANALYGIA OF HOODITAL BAGES BUG (FOUR COOTS		D 1 1 0001 44 4007	6	101 1 1 1 1 1

Heal th	Financial Systems WAE	SASH GENERAL HOS	SPITAL DISTRIC	T	In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1327	Peri od:	Worksheet M-1	
					From 01/01/2023		
			Component	CCN: 14-8613	To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC VI	Cost	UZ alli
		Compensation	Other Costs	Total (col.		Recl assi fi ed	
		Compensation	other costs	+ col . 2)	ions	Tri al Balance	
				1 (01. 2)	1 0113	(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 0	0	1.00
2.00	Physici an Assistant	o	0		0 0	0	2.00
3.00	Nurse Practitioner	0	0		0 263, 210	263, 210	3.00
4.00	Visiting Nurse	o	0)	0 0	0	4.00
5. 00	Other Nurse	o	0		0 167, 377	167, 377	5.00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7. 00
7. 10	Marriage and Family Therapist		· ·			Ĭ	7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0	,	0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0 143	143	9.00
10.00	Subtotal (sum of lines 1 through 9)	o o	0		0 430, 730	l e	10.00
11. 00	Physician Services Under Agreement	Ö	0		0 100, 700	0	11.00
12. 00	Physician Supervision Under Agreement	٥	0		0	Ö	12.00
13. 00	Other Costs Under Agreement		0			Ö	13.00
14. 00	Subtotal (sum of lines 11 through 13)	o	0			Ö	14. 00
15. 00	Medical Supplies	0	29, 460	29, 40	50 0	29, 460	15.00
16. 00	Transportation (Health Care Staff)	0	27, 400	27, 70		0	16. 00
17. 00	Depreciation-Medical Equipment	0	0			Ö	17.00
18. 00	Professional Liability Insurance		0			0	18. 00
19. 00	Other Health Care Costs		0			0	19.00
20. 00	Allowable GME Costs		0			0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	29, 460	29, 40	50	29, 460	21.00
22. 00	Total Cost of Health Care Services (sum of	0	29, 460				22.00
22.00	lines 10, 14, and 21)	o o	27, 400	27, 40	430, 730	400, 190	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	o o	0	1	0 0	Ö	24. 00
25. 00	Optometry	0	0		0 0	Ö	25. 00
25. 00	Tel eheal th		0			Ö	25. 00
25. 01	Chronic Care Management		0			0	25. 01
26. 00	All other nonreimbursable costs	0	0			0	26.00
27. 00	Nonallowable GME costs	o o	0			0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
20.00	through 27)	٥	U		0	0	26.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	O	17, 323	17, 32	23 0	17, 323	29. 00
30. 00	Administrative Costs	574, 417	228, 994				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	574, 417	246, 317				31.00
51.00	30)	3/4,41/	240, 317	020, 7.	-430, /30	370,004	31.00
32. 00	Total facility costs (sum of lines 22, 28	574, 417	275, 777	850, 19	04	850, 194	32. 00
32.00	and 31)	3/4,41/	213,111	050, 1	/-	050, 194	32.00
	1	ı I		1	I	Į	1

			Component	CCN: 14-8613	To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC VI	Cost	<u> </u>
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col . 6)	_			
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7. 00				
1. 00	FACILITY HEALTH CARE STAFF COSTS Physi ci an	Ol	C	1			1.00
2. 00	Physician Assistant	0	C	1			2.00
3. 00	Nurse Practitioner	0	263, 210				3.00
4. 00	Visiting Nurse	0	200, 210	1			4.00
5. 00	Other Nurse	0	167, 377				5.00
6. 00	Clinical Psychologist	o	C	. 1			6.00
7.00	Clinical Social Worker	o	C				7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	C				8.00
9.00	Other Facility Health Care Staff Costs	0	143				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	430, 730)			10.00
11. 00	Physician Services Under Agreement	0	C	1			11.00
12. 00	Physician Supervision Under Agreement	0	C	1			12.00
13. 00	Other Costs Under Agreement	0	C	1			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	29, 460	1			15.00
16.00	Transportation (Health Care Staff)	0	C				16. 00 17. 00
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	C				18.00
19.00	Other Health Care Costs	0	C	1			19.00
20. 00	Allowable GME Costs	o _l	C	ή			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	29, 460				21.00
22. 00	Total Cost of Health Care Services (sum of	0	460, 190	•			22.00
	lines 10, 14, and 21)		,				
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	C				23.00
24.00	Dental	0	C)			24.00
25. 00	Optometry	0	C	1			25.00
25. 01	Tel eheal th	0	C	1			25. 01
25. 02	Chronic Care Management	0	C	1			25. 02
26. 00	All other nonreimbursable costs	0	C				26.00
27. 00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)			28. 00
	through 27) FACILITY OVERHEAD						1
29 00	Facility Costs	35, 086	52, 409				29. 00
30.00	Administrative Costs	-11, 935	360, 746	•			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	23, 151	413, 155	1			31.00
	30)	20, .01	, 100				
32.00	Total facility costs (sum of lines 22, 28	23, 151	873, 345	5			32.00
	and 31)						

		BASH GENERAL HO				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col . 3)	col . 4	
	h	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	0.05	4 500	4 00/	4 470		1 00
1.00	Physi ci an	0. 35					1.00
2.00	Physician Assistant	0. 42	1, 867 9	2, 100			2.00
3. 00 4. 00	Nurse Practitioner	0. 01 0. 78		2, 100		3, 376	
5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.78			2, 373	3,376	5.00
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00				0	7.02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	0. 78	3, 376			3, 376	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEF	RVICES		1.00	
10.00	Total costs of health care services (from Wk					284, 080	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12.00	Cost of all services (excluding overhead) (s					284, 080	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. !	M-1, col. 7, li	ne 31)		26, 198	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			378, 261	15.00
16.00	Total overhead (sum of lines 14 and 15)					404, 459	16.00
17.00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16					404, 459	
19. 00	Overhead applicable to hospital-based RHC/FC					404, 459	
20. 00	Total allowable cost of hospital-based RHC/F	FQHC services (sum of lines 10	o and 19)		688, 539	20.00

		BASH GENERAL HO	SPITAL DISTRIC	T .	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 14-1327	Peri od:	Worksheet M-2	
			Component	CCN: 14-8568	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
4 00	Posi ti ons	0.74			4		1
1.00	Physician	2. 61			1 3		1.00
2.00	Physician Assistant	1. 46					2.00 3.00
3. 00 4. 00	Nurse Practitioner	0. 84 4. 91	2, 130 11, 512			11, 512	
5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.00			5	11,512	
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00	Ĭ				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	4. 91	11, 512			11, 512	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPLTAL-BASE	FD RHC/FOHC SEI	RVLCES		1.00	
10.00	Total costs of health care services (from Wk					2, 307, 730	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			2, 307, 730	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, li	ne 31)		525, 782	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			757, 340	
16.00	Total overhead (sum of lines 14 and 15)					1, 283, 122	
17.00	Allowable GME overhead (see instructions)						17.00
18. 00	Enter the amount from line 16					1, 283, 122	
19. 00	Overhead applicable to hospital-based RHC/FC					1, 283, 122	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (:	sum of lines 10	J and 19)		3, 590, 852	20.00

Heal th	Financial Systems WAE	BASH GENERAL HO	SPITAL DISTRIC	.T	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der C	CN: 14-1327	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-2	
						5/17/2024 11:	
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	2.00	1 x col . 3)	col . 4	
	VICITE AND DRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1. 00	Physi ci an	0. 90	3, 908	4, 20	0 3, 780		1.00
2. 00	Physician Assistant	0. 90					2.00
3. 00	Nurse Practitioner	0.00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 70		2,10	5, 460	5, 981	4.00
5. 00	Visiting Nurse	0.00			0, 100	0, 701	5.00
6. 00	Clinical Psychologist	0.00				Ö	
7. 00	Clinical Social Worker	0.00				Ō	•
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
	onl y)						
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. 70	5, 981			5, 981	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES		1.00	
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 035, 105	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 035, 105	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		193, 259	ı
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			417, 928	1
16. 00	Total overhead (sum of lines 14 and 15)					611, 187	
17. 00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16			4.0)		611, 187	1
19. 00	Overhead applicable to hospital-based RHC/FO					611, 187	
20.00	Total allowable cost of hospital-based RHC/F	unc services (Sum of Tines 10	o and 19)		1, 646, 292	₁ 20.00

		BASH GENERAL HO	SPITAL DISTRIC	T .	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component (From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC IV	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 96					1.00
2.00	Physician Assistant	0. 53					2.00
3.00	Nurse Practitioner	0. 86					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 35			6, 951	7, 289	4.00
5. 00 6. 00	Visiting Nurse	0. 00 0. 00				0	5.00
7. 00	Clinical Psychologist Clinical Social Worker	0.00				0	
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7.01
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. 35	7, 289			7, 289	8.00
0.00	through 7)	2.00	,,20,			,,20,	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	ED RHC/FOHC SEE	RVLCES		1.00	
10.00	Total costs of health care services (from Wk			525		932, 049	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,						11.00
12. 00	Cost of all services (excluding overhead) (s					932, 049	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		439, 252	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	,		393, 225	15. 00
16.00	Total overhead (sum of lines 14 and 15)		ŕ			832, 477	16.00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					832, 477	18. 00
19.00	Overhead applicable to hospital-based RHC/FC					832, 477	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	o and 19)		1, 764, 526	20.00

		BASH GENERAL HO	SPITAL DISTRIC	т _	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (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
1.00	Physi ci an	0. 68	2, 867	4, 20	0 2, 856		1.00
2.00	Physician Assistant	0. 10	318	2, 10	0 210		2.00
3.00	Nurse Practitioner	0. 67	1, 347	2, 10	0 1, 407		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 45			4, 473	4, 532	
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00	l .			0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7.03
7. 04	Mental Health Counselor	4 45	4 500			4 500	7.04
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	1. 45	4, 532			4, 532	8.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPLTAL-BASE	FD_RHC/FOHC_SE	RVLCES		1. 00	
10.00	Total costs of health care services (from Wk			020		620, 360	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12. 00	Cost of all services (excluding overhead) (s					620, 360	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. 1	M-1, col. 7, li	ine 31)		479, 985	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	ŕ		268, 645	15.00
16.00	Total overhead (sum of lines 14 and 15)	-				748, 630	16.00
17.00	Allowable GME overhead (see instructions)					0	1
18.00	Enter the amount from line 16					748, 630	
19. 00	Overhead applicable to hospital-based RHC/FQ					748, 630	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	0 and 19)		1, 368, 990	20.00

Heal th	Financial Systems WAB	BASH GENERAL HO	SPITAL DISTRIC	Т	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der C	CN: 14-1327	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-2	
			Component	0010. 14 0015		5/17/2024 11:	
					RHC VI	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1	_		_1		
1.00	Physi ci an	0.00					1.00
2.00	Physician Assistant	0.00		_,			2.00
3. 00	Nurse Practitioner	1. 66	· ·		· ·		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 66			3, 486	3, 749	4.00
5. 00	Visiting Nurse	0.00				0	
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
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. 66	3, 749			3, 749	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						1 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPLTAL-BASE	FD RHC/FOHC SE	RVLCES		1. 00	
10.00	Total costs of health care services (from Wk					460, 190	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	·				0	•
12.00	Cost of all services (excluding overhead) (s					460, 190	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		413, 155	l
15. 00	Parent provider overhead allocated to facili			,		213, 446	ı
16. 00	Total overhead (sum of lines 14 and 15)	., (222 :50, 0	/			626, 601	ł
17. 00	Allowable GME overhead (see instructions)					0	1
18. 00	Enter the amount from line 16					626, 601	
19. 00	Overhead applicable to hospital-based RHC/FC	HC services (I	ine 13 x line	18)		626, 601	ł
	Total allowable cost of hospital-based RHC/F					1, 086, 791	
				,	'		

CALCULA	Financial Systems WABASH GENERAL HOSPI TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CE		Component CCN: 14-8501	From 01/01/2023 To 12/31/2023	Date/Time Pre	
		·		5/17/2024 11:	02 an
		Title XVIII	RHC I	Cost	
le le	DETERMINATION OF DATE FOR HOCKLIAL DACED DUG/FOUG CERVILORS			1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst M-2 line 20)		688, 539	1.0
	Cost of injections/infusions and their administration (from W			000, 557	1
	Total allowable cost excluding injections/infusions (line 1 m			688, 539	1
- 1	Total Visits (from Wkst. M-2, column 5, line 8)			3, 376	1
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2 274	5.
- 1	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			3, 376 203. 95	
. 00	najusted cost per visit (iiile s divided by iiile o)		Cal cul ati on		
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023) 2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20), 6 or vour contractor)	0.00	197. 37	8.
- 1	Rate for Program covered visits (see instructions)		0.00	197. 37	1
	CALCULATION OF SETTLEMENT			150	
- 1	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	459 90, 593	10.
- 1	Program covered visits for mental health services (from contr		o	70, 373	1
	Program covered cost from mental health services (line 9 x li	•	0	0	13.
- 1	Limit adjustment for mental health services (see instructions	*	0	0	
- 1	Graduate Medical Education Pass Through Cost (see instruction	•	0	00 503	15.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re		U	90, 593 62, 992	
	Total program preventive charges (see instructions)(from prov	•		600	1
6. 03	Total program preventive costs ((line 16.02/line 16.01) times	s line 16)		863	16.
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		64, 606	16.
6. 05	Total program cost (see instructions)		0	65, 469	16.
- 1	Primary payer amounts			0	17.
	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 972	18.
1	records) Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		10, 653	10
	records)	ms) (Trom contractor		10, 033	' '
	Net program cost excluding injections/infusions (see instruct	•		65, 469	
	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		0	21. 21.
	Total program IOP Costs (see instructions)				21.
	Program IOP deductible and coinsurance (see instructions)				21.
2. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		65, 469	22.
	Allowable bad debts (see instructions)				23.
	Adjusted reimbursable bad debts (see instructions)	-musti ana)		0	
- 1	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Tuctions)		0	24. 25.
- 1	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
- 1	Demonstration payment adjustment amount before sequestration			0	25.
- 1	Net reimbursable amount (see instructions)			65, 469	1
1	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			1, 309 0	
1	Interim payments			47, 391	
- 1	Tentative settlement (for contractor use only)			0	
9. 00	Balance due component/program (line 26 minus lines 26.01, 26.	· · · · · · · · · · · · · · · · · · ·		16, 769	1
30.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-II	1	0	30.

CALCULA	Financial Systems WABASH GENERAL HOSPI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CI		Component CCN: 14-8568	From 01/01/2023 To 12/31/2023	Date/Time Pre	
				5/17/2024 11:	02 am
		Title XVIII	RHC I I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	WI - 1 M O I I - 200		2 500 050	١.,
	Total Allowable Cost of hospital-based RHC/FQHC Services (fro Cost of injections/infusions and their administration (from W			3, 590, 852 25, 512	1
. 00	Total allowable cost excluding injections/infusions (line 1 m			3, 565, 340	1
	Total Visits (from Wkst. M-2, column 5, line 8)	irius iriic 2)		11, 512	
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	1
	Total adjusted visits (line 4 plus line 5)			11, 512	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			309. 71	7.
			Calculation	of Limit (1)	
				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, chapter 9, §20	0.6 or your contractor)	0.00	381. 13	8.
	Rate for Program covered visits (see instructions)		0.00	309. 71	9.
	CALCULATION OF SETTLEMENT			1 520	10
	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	1, 539 476, 644	1
	Program covered visits for mental health services (from contr				12.
	Program covered cost from mental health services (line 9 x li	•	o	0	1
	Limit adjustment for mental health services (see instructions		o	0	1
5. 00	Graduate Medical Education Pass Through Cost (see instruction	ns)			15.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	476, 644	1
	Total program charges (see instructions)(from contractor's re	*		234, 803	
	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		14, 933 30, 314	
	Total Program non-preventive costs ((Time 16.02/Time 16.07) times	•		343, 985	1
	(Titles V and XIX see instructions.)	, , , , , , , , , , , , , , , , , , , ,			
- 1	Total program cost (see instructions)		0	374, 299	
	Primary payer amounts			0	17.
8. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		16, 349	18.
9. 00	recorus) Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		40, 684	19.
	records)	, (,	
	Net program cost excluding injections/infusions (see instruct	,		374, 299	
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		17, 195	
	Total program IOP OPPS payments (see instructions) Total program IOP Costs (see instructions)				21.
	Program IOP deductible and coinsurance (see instructions)				21.
	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		391, 494	1
	Allowable bad debts (see instructions)	,			23.
3. 01	Adjusted reimbursable bad debts (see instructions)			455	23.
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)			24.
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				25.
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 391, 949	1
	Sequestration adjustment (see instructions)			7, 839	
- 1	Demonstration payment adjustment amount after sequestration			0	
1	Interim payments			409, 019	
	Tentative settlement (for contractor use only)			0	
- 1	Balance due component/program (line 26 minus lines 26.01, 26.	•		-24, 909	1
30.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Dub 15-11	1	0	30.

SERVI C	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
	ES	Component CCN: 14-8579	From 01/01/2023 To 12/31/2023	Date/Time Pre	
				5/17/2024 11:	02 an
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	W	1	1 / / / 000	ļ.,
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 646, 292	1
. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			136, 772 1, 509, 520	1
00	Total Visits (from Wkst. M-2, column 5, line 8)	irius irrie 2)		5, 981	4.
00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 701	1
. 00	Total adjusted visits (line 4 plus line 5)	,		5, 981	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			252. 39	7.
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1. 00	12/31/2023) 2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	0.00	225. 78	8.
. 00	Rate for Program covered visits (see instructions)		0.00	225. 78	
	CALCULATION OF SETTLEMENT				
0. 00	Program covered visits excluding mental health services (from		0	3, 878	
. 00	Program cost excluding costs for mental health services (line	•	0	875, 575	1
2.00	Program covered visits for mental health services (from contr	*	0	0	12.
3. 00 4. 00	Program covered cost from mental health services (line 9 \times li Limit adjustment for mental health services (see instructions	•	0	0	
5. 00	Graduate Medical Education Pass Through Cost (see instruction	•	ď	O	15.
6. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	875, 575	1
6. 01	Total program charges (see instructions)(from contractor's re	*		568, 596	1
6. 02	Total program preventive charges (see instructions)(from prov	ider's records)		15, 187	16.
6. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		23, 387	
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		619, 564	16.
6. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		o	642, 951	16
7. 00	Primary payer amounts		Ĭ	042, 731	
8. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		77, 733	1
	records)				
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		94, 984	19.
0.00	Net program cost excluding injections/infusions (see instruct	i ons)		642, 951	20.
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		82, 089	21.
1. 50	Total program IOP OPPS payments (see instructions)				21.
1. 55	, ,				21.
1. 60	Program IOP deductible and coinsurance (see instructions)	minus line 21 (0)		705 040	21.
2.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, Allowable bad debts (see instructions)	minus iine 21.60)		725, 040	23.
	Adjusted reimbursable bad debts (see instructions)			0	1
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		-	24.
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
5. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25.
5. 99	Demonstration payment adjustment amount before sequestration			0	25.
6.00	Net reimbursable amount (see instructions)			725, 040	
26. 01	Sequestration adjustment (see instructions)			14, 501	1
6. 02 7. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 629, 397	
8. 00	Triterim payments Tentative settlement (for contractor use only)			029, 397	
		00 07 1 00)		81, 142	
9. 00	Balance due component/program (line 26 minus lines 26.01, 26.	U2. 27. and 781		01.147	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-E	BASED RHC/FQHC	TAL DISTRICT Provider CCN: 14-1327	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 14-8599	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
		Title XVIII	RHC IV	Cost	02 011
				1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQ	HC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC	Services (fro	m Wkst. M-2, line 20)		1, 764, 526	1. (
.00 Cost of injections/infusions and their administ	•			95, 119	1
00 Total allowable cost excluding injections/infus	•	ninus line 2)		1, 669, 407	
.00 Total Visits (from Wkst. M-2, column 5, line 8)				7, 289	1
.00 Physicians visits under agreement (from Wkst. M	l-2, column 5,	line 9)		0	
.00 Total adjusted visits (line 4 plus line 5)	()			7, 289	1
.00 Adjusted cost per visit (line 3 divided by line	6)		Cal cul ati on	229.03 of Limit (1)	7.
				Rate Period 1	
			N/A	(01/01/2023 through	
				12/31/2023)	
			1.00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04,	chapter 9, §20	0.6 or your contractor)	0.00	197. 25	8.
.00 Rate for Program covered visits (see instruction	ns)		0. 00	197. 25	9.
CALCULATION OF SETTLEMENT					
0.00 Program covered visits excluding mental health			0	2, 941	1
1.00 Program cost excluding costs for mental health	,	*	0	580, 112	
2.00 Program covered visits for mental health service	•	•	0	0	1
3.00 Program covered cost from mental health service 4.00 Limit adjustment for mental health services (se		•	0	0	
5.00 Graduate Medical Education Pass Through Cost (s		•	U	U	15.
6.00 Total Program cost (sum of lines 11, 14, and 15		•	0	580, 112	
6.01 Total program charges (see instructions)(from c		•	Ĭ	392, 748	1
6.02 Total program preventive charges (see instructi		•		20, 852	1
6.03 Total program preventive costs ((line 16.02/lin	e 16.01) times	sline 16)		30, 800	16.
6.04 Total Program non-preventive costs ((line 16 mi	nus lines 16.0	3 and 18) times .80)		394, 228	16.
(Titles V and XIX see instructions.)					
6.05 Total program cost (see instructions)			0	425, 028	1
7.00 Primary payer amounts	i notruoti ono)	(from contractor		0	1
8.00 Less: Beneficiary deductible for RHC only (see records)	instructions)	(from contractor		56, 527	18.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		63, 025	19.
records)		,			
20.00 Net program cost excluding injections/infusions	•	•		425, 028	1
1.00 Program cost of vaccines and their administrati	•	M-4, line 16)		53, 069	1
1.50 Total program IOP OPPS payments (see instruction	ns)				21.
1.55 Total program IOP Costs (see instructions)	±				21.
1.60 Program IOP deductible and coinsurance (see ins 2.00 Total reimbursable Program cost (sum of lines 2		minus Lino 21 60)		478, 097	21.
3.00 Allowable bad debts (see instructions)	.0, 21, 21.30,	illi ilus Title 21.00)		501	1
3.01 Adjusted reimbursable bad debts (see instructions)	ns)				23.
4.00 Allowable bad debts for dual eligible beneficia		ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(111	,			25.
5.50 Pioneer ACO demonstration payment adjustment (s				0	25.
5.99 Demonstration payment adjustment amount before	sequestrati on			0	
6.00 Net reimbursable amount (see instructions)				478, 423	
6.01 Sequestration adjustment (see instructions)				9, 568	
6.02 Demonstration payment adjustment amount after s	equestrati on			0	
7.00 Interim payments				415, 071	
18.00 Tentative settlement (for contractor use only)19.00 Balance due component/program (line 26 minus li	nes 26 01 24	02 27 and 20)		0 53, 784	1
19.00 Barance due component/program (Trne 26 minus 17 10.00 Protested amounts (nonallowable cost report ite					30.
o. oo ii i o coo coa amourico (nonari owabi e coo ci ebbli ci le	mor in accorda	mice with own rub. 19-11	,		ı JU.

CALCUL	Financial Systems WABASH GENERAL HOSPI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 14-8601	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
		T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DUC V	5/17/2024 11:	02 am
		Title XVIII	RHC V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	Wist M 2 15 - 20)		1 2/0 000	1,
.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 368, 990	1.
. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			101, 231 1, 267, 759	1
. 00	Total Visits (from Wkst. M-2, column 5, line 8)	irius rine 2)		4, 532	1
00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	1
. 00	Total adjusted visits (line 4 plus line 5)	•		4, 532	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			279. 73	7.
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023) 2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	291.86	8.
. 00	Rate for Program covered visits (see instructions)		0.00	279. 73	1
	CALCULATION OF SETTLEMENT				
0. 00	Program covered visits excluding mental health services (from	,	0	2, 621	
1.00	Program cost excluding costs for mental health services (line		0	733, 172	1
2. 00 3. 00	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li	•	0	0	12.
4. 00	Limit adjustment for mental health services (see instructions		0	0	
5. 00	Graduate Medical Education Pass Through Cost (see instruction	•		ū	15.
6. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	o	733, 172	16.
6. 01	Total program charges (see instructions)(from contractor's re	ecords)		494, 983	16.
6. 02	Total program preventive charges (see instructions)(from prov			28, 680	1
6. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		42, 481	1
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		527, 654	16.
6. 05	Total program cost (see instructions)		0	570, 135	16
7. 00	Primary payer amounts			0	17.
8. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		31, 124	18.
	records)				
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		86, 972	19.
0. 00	Net program cost excluding injections/infusions (see instruct	i ons)		570, 135	20.
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		35, 847	1
	Total program IOP OPPS payments (see instructions)				21.
1. 55 1. 60	Total program IOP Costs (see instructions) Program IOP deductible and coinsurance (see instructions)				21.
	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21 60)		605, 982	1
	Allowable bad debts (see instructions)	III 11d3 1111C 21.00)			23.
	Adjusted reimbursable bad debts (see instructions)				23.
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)			24.
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	
5. 99	Demonstration payment adjustment amount before sequestration			0	25.
6. 00 6. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			606, 055 12, 121	1
6. 02	Demonstration payment adjustment amount after sequestration			12, 121	
7. 00	Interim payments			435, 599	
8. 00	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		158, 335	
29. 00			,		

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1327	Peri od:	Worksheet M-3	
ERVI CES	Component CCN: 14-8613	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/17/2024 11:	
	Title XVIII	RHC VI	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 086, 791	1. (
00 Cost of injections/infusions and their administration (from W			90, 183	1
Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		996, 608	1
OD Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line ()		3, 749 0	1
OD Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	111le 9)		3, 749	
00 Adjusted cost per visit (line 3 divided by line 6)			265. 83	1
inajastou osot per visit (vino o arviaca sy vino o)		Cal cul ati on		7.
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
		14771	through	
			12/31/2023)	
		1. 00	2.00	
OO Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20). 6 or your contractor)	0. 00	301. 09	
00 Rate for Program covered visits (see instructions)		0.00	265. 83	9.
CALCULATION OF SETTLEMENT	contractor records)	0	1 400	10
D.OO Program covered visits excluding mental health services (from 1.00 Program cost excluding costs for mental health services (line		0	1, 423 378, 276	1
2.00 Program covered visits for mental health services (from contr	,	0	370, 270	
3.00 Program covered cost from mental health services (line 9 x li	•	0	0	1
4.00 Limit adjustment for mental health services (see instructions	•	0	0	
5.00 Graduate Medical Education Pass Through Cost (see instruction	is)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	378, 276	1
6.01 Total program charges (see instructions)(from contractor's re	•		212, 514	1
6.02 Total program preventive charges (see instructions)(from prov			11, 206	1
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	•		19, 947 267, 906	1
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	os and 16) trilles . 60)		207, 900	10.
6.05 Total program cost (see instructions)		0	287, 853	16.
7.00 Primary payer amounts			0	
3.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		23, 446	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		35, 427	19.
0.00 Net program cost excluding injections/infusions (see instruct	i ons)		287, 853	20.
1.00 Program cost of vaccines and their administration (from Wkst.	•		45, 049	1
1.50 Total program IOP OPPS payments (see instructions)				21.
1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)			222 222	21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		332, 902	1
3.00 Allowable bad debts (see instructions) 3.01 Adjusted reimbursable bad debts (see instructions)			189	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	40 (1. 61.6)			25.
5.50 Pioneer ACO demonstration payment adjustment (see instruction			0	1
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			333, 025	1
6.01 Sequestration adjustment (see instructions)			6, 661	1
6.02 Demonstration payment adjustment amount after sequestration			270 010	
7.00 Interim payments 3.00 Tentative settlement (for contractor use only)			279, 919 0	1
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		46, 445	1
0.00 Protested amounts (nonallowable cost report items) in accorda	· · · · · · · · · · · · · · · · · · ·	,		30.
		[· ·	1

	Financial Systems WABASH GENERAL HO ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider C		Peri od:	u of Form CMS-2 Worksheet M-4	
COIVII O I	ATTON OF HOSELTINE BASED KIRCT QUE VACCINE 6031			From 01/01/2023		
		Component (CCN: 14-8568	To 12/31/2023	Date/Time Pre 5/17/2024 11:	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
		1.00		0.01	PRODUCTS	
1 00	H. J. H	1.00	2.00	2. 01	2. 02	1 00
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 247, 069	2, 247, 06			
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000261	0. 00093	0. 000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line	586	2, 09	90	o	3.00
3.00	2)	300	2, 0	,0	U	3.00
4. 00	Injections/infusions and related medical supplies costs	3, 460	10, 26	0	o	4.00
	(from your records)		,			
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4, 046	12, 35	50 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	2, 307, 730	2, 307, 73	2, 307, 730	2, 307, 730	6.00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	1, 283, 122	1, 283, 12			7.00
8. 00	Ratio of injection/infusion direct cost to total direct	0. 001753	0. 00535	0. 000000	0. 000000	8. 00
	cost (line 5 divided by line 6)	0.040				
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2, 249	6, 86		0	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 295	19, 21	17 0	0	10.00
11. 00	Total number of injections/infusions (from your records)	16		57 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	393. 44	337.		-	12.00
13. 00	Number of injection/infusion administered to Program	12		37 0	0.00	
	beneficiaries		`		, and the second se	
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14.00	Program cost of injections/infusions and their	4, 721	12, 47	74 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)				2007.05	
					COST OF	
					INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administration		f columns 1,		25, 512	15.00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.					
16. 00	Total Program cost of injections/infusions and their admin				17, 195	16. 00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

JOMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od:	Worksheet M-4	
		Component (From 01/01/2023 Fo 12/31/2023	Date/Time Pre	
			20/11/1	500 111	5/17/2024 11:	02 am
		Title		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)	1, 004, 423	1, 004, 423			1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001555	0. 016026	0. 000000	0. 000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 562	16, 097	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	7, 136	61, 200	0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	8, 698	77, 297		0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 035, 105	1, 035, 105	1, 035, 105	1, 035, 105	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	611, 187	611, 187		611, 187	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 008403	0. 074676	0. 000000	0. 000000	8.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	5, 136	45, 641	0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13, 834	122, 938	0	0	
11. 00	Total number of injections/infusions (from your records)	33	340		0	
12. 00	Cost per injection/infusion (line 10/line 11)	419. 21	361. 58			
13. 00	Number of injection/infusion administered to Program beneficiaries	19	205	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)	7, 965	74, 124	1 0	0	14.00
	juna 10.01, us approcasio)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
15.00	Total and of initiations (infinites and their sections)		S1	1. 00	2.00	15.00
15.00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns I,		136, 772	15.00
16 00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of	1	82, 089	16.00

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od:	Worksheet M-4	
		Component C		From 01/01/2023 o 12/31/2023		
		Title	VVIII	RHC IV	5/17/2024 11:0 Cost	02 am
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	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)	898, 139	898, 139			1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000136	0. 007945	0.000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 \times line 2)	122	7, 136	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	865	42, 120	0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	987	49, 256		0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	932, 049	932, 049			6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	832, 477	832, 477			7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 001059	0. 052847	0. 000000	0. 000000	8. 00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	882	43, 994		0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1, 869	93, 250		0	
11.00	Total number of injections/infusions (from your records)	4	234		0	
12.00	Cost per injection/infusion (line 10/line 11)	467. 25	398. 50			12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	1	132		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)	467	52, 602	0	0	14.00
	and totol, de applitousloy				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
15.00	Total and a Children Park Colours and the children		- 1	1.00	2. 00	45.00
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			95, 119	
1 / 00	Total Program cost of injections/infusions and their admin		. / E	1	53, 069	1 1/ 00

COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC Component C		Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	XV/LLL	RHC V	5/17/2024 11: Cost	<u>02 am</u>
		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)	592, 282	592, 28		592, 282	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 002155	0. 00939	0. 000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 276	5, 56	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	8, 433	30, 60	00	0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	9, 709	36, 16	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	620, 360	620, 36	620, 360	620, 360	6.00
7. 00	Total overhead (from Wkst. M-2, line 19)	748, 630	748, 63	748, 630	748, 630	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 015651	0. 05829	0. 000000	0. 000000	8.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	11, 717	43, 64	1 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	21, 426	79, 80	05 0	0	10.00
11.00	Total number of injections/infusions (from your records)	39	17		0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	549. 38	469. 4	0.00	0. 00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	8	6	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)	4, 395	31, 45	52 0	0	14.00
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMI NI STRATI O	
				1 00	N 2.00	
15 00	Total cost of injections/infusions and their administration	a costs (sum of	columns 1	1.00	2. 00 101, 231	15.00
13.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		101, 231	15.00
16. 00	Total Program cost of injections/infusions and their admini		s (sum of		35, 847	16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amour					1

COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC Component C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Pre 5/17/2024 11:	pared:
		Title	XVIII	RHC VI	Cost	OZ dili
		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	430, 730 0. 000048	430, 73 0. 00912			
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line	21	3, 93	0	0	3.00
4. 00	2) Injections/infusions and related medical supplies costs (from your records)	216	34, 02	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)	237 460, 190	37, 95 460, 19		0 460, 190	
7. 00	Total overhead (from Wkst. M-2, line 19)	626, 601	626, 60	626, 601	626, 601	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000515	0. 08246			
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	323 560	51, 67 89, 62		0 0	
11. 00	costs (sum of lines 5 and 9) Total number of injections/infusions (from your records)	1	18	39 0	0	11.00
12. 00	Cost per injection/infusion (line 10/line 11)	560.00	474. 2			12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	0	9	95 0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	45, 04	19 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	N 2. 00	
15. 00	Total cost of injections/infusions and their administration		columns 1,	1.00	90, 183	15.00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admini				45, 049	1

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHO SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provi der CCN: 14-1327 Component CCN: 14-8501	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

		Component Con. 14-8301	10 12/31/2023	5/17/2024 11: (
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			52, 876	1. (
2. 00	Interim payments payable on individual bills, either submitt	ted or to be submitted to		0	2. 0
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3. 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				
3. 01				0	3.
. 02				o	3.
3. 03				l ol	3.
3. 04				o	3.
3. 05				o	3.
	Provider to Program		<u> </u>		
. 50			08/24/2023	5, 485	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)		-5, 485	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf			47, 391	4.
	27)			,	
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after desk	review. Also show date o	F		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01	<u> </u>			0	5.
. 02					_
				1 01	5.
				0	-
	Provider to Program			1 -1	-
. 03	Provider to Program			1 -1	5.
. 03	Provider to Program			0	5. 5.
. 03 . 50 . 51	Provider to Program			0	5. 5. 5.
. 03 . 50 . 51 . 52	Provider to Program Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		0 0	5. 5. 5.
. 03 . 50 . 51 . 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0 0 0	5. 5. 5. 5.
. 03 . 50 . 51 . 52 . 99 . 00				0 0 0 0 0	5. 5. 5. 5. 6.
. 03 . 50 . 51 . 52 . 99 . 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER			0 0 0	5. 5. 5. 5. 6.
5. 50 5. 51 5. 52 5. 99 5. 00 6. 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0 0 0 0 16, 769	5. 5. 5. 5. 6. 6.
i. 03 i. 50 i. 51 i. 52 i. 99 i. 00 i. 01 i. 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER		Contractor	0 0 0 0 0 16, 769 0 64, 160	5. 5. 5. 5. 6. 6.
5. 03 5. 50 5. 51 5. 52 5. 99 5. 00 5. 01 5. 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor	0 0 0 0 0 16, 769 0 64, 160 NPR Date	5. 5. 5. 5. 6. 6.
5. 02 5. 03 5. 50 5. 51 5. 52 5. 99 6. 00 6. 01 6. 02 7. 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor Number 1.00	0 0 0 0 0 16, 769 0 64, 160	5. 5. 5. 5. 6. 6. 7.

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provi der CCN: 14-1327 Component CCN: 14-8568	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

				5/17/2024 11:0	02 am
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			411, 374	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l ol	2.00
	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 amount	: based on subsequent			3.00
	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				0	3.0
3.02				0	3.0
3.03				0	3.0
3.04				0	3.0
3.05				0	3.0
	Provider to Program				
3.50			08/24/2023	2, 355	3.5
3. 51				0	3.5
3. 52				0	3.5
3. 53				0	3.5
3.54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		-2, 355	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		409, 019	4.0
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date of			5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.0
5. 02				0	5. C
5. 03				0	5. C
	Provider to Program				
5. 50				0	5.5
5. 51				0	5. 5
5. 52				0	5.5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 9
5. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.0
6. 01	SETTLEMENT TO PROVIDER			0	6.0
6. 02	SETTLEMENT TO PROGRAM			24, 909	6. C
7. 00	Total Medicare program liability (see instructions)			384, 110	7.0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8.00	Name of Contractor				8.00

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	C PROVIDER FOR	Provider CCN: 14-1327 Component CCN: 14-8579	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

				5/17/2024 11:0	02 am
			RHC III	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			629, 397	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.00
	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 amount	: based on subsequent			3.00
	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				0	3.01
3.02				0	3. 02
3.03				0	3.03
3.04				o	3.04
3.05				o	3. 05
	Provider to Program				
3.50				0	3.50
3. 51				ol	3.5
3. 52				ol	3. 52
3. 53				l ol	3. 53
3. 54				l ol	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		l ol	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			629, 397	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		•		
5.00	List separately each tentative settlement payment after des	sk review. Also show date of	-		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		1		
5. 01	<u> </u>			0	5. 0 ²
5. 02				ol	5.02
5. 03				ol	5.03
	Provider to Program		•		
5.50	· · · · · · · · · · · · · · · · · · ·			0	5. 50
5. 51				ol	5.5
5. 52				ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		l ol	5. 99
6.00	Determined net settlement amount (balance due) based on the				6.00
6. 01	SETTLEMENT TO PROVIDER			81, 142	6.0
6. 02	SETTLEMENT TO PROGRAM			01,112	6. 02
7. 00	Total Medicare program liability (see instructions)			710, 539	7. 00
00	Total mode out of program traditity (300 thistractions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provider CCN: 14-1327 Component CCN: 14-8599	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

		Component Con. 14-0377	10 12/31/2023	5/17/2024 11:0	
			RHC IV	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			415, 071	1.0
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	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 amount				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				
3. 01				0	3.
3. 02				0	3. (
3. 03				0	3.
3. 04				0	3.
3. 05				o	3.
	Provider to Program				
. 50	-			0	3.
. 51				ol	3.
. 52				0	3.
. 53				o	3.
3. 54				o	3.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		415, 071	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	k review. Also show date o	f		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.	98)		0	5.
	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
. 00	SETTLEMENT TO PROVIDER			53, 784	6.
				ا ما	6.
. 01	SETTLEMENT TO PROGRAM				
. 01				468, 855	7.
o. 01 o. 02	SETTLEMENT TO PROGRAM		Contractor	١	7.
5. 01 5. 02	SETTLEMENT TO PROGRAM		Contractor Number	468, 855	7.
6. 00 6. 01 6. 02 7. 00	SETTLEMENT TO PROGRAM	0		468,855 NPR Date	7.

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHO SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provi der CCN: 14-1327 Component CCN: 14-8601	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

		Component con. 14-0001	10 12/31/2023	5/17/2024 11:	
			RHC V	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			497, 741	1. (
2. 00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.0
	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 amount	t 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				0	3.
3. 02				0	3.
. 03				l ol	3.
. 04				l ol	3.
8. 05				0	3.
	Provider to Program		<u>'</u>		
. 50			08/24/2023	62, 142	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.	. 98)		-62, 142	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		,	435, 599	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		ĺ
. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		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	
. 51				0	5.
. 52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			158, 335	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			593, 934	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
3. 00	Name of Contractor	0	1. 00	2. 00	8.

Health Financial Systems	WABASH GENERAL HOSPI	TAL DISTRICT	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVI DER FOR	Provider CCN: 14-1327 Component CCN: 14-8613	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am

		Component Con. 14-8013	0 12/31/2023	5/17/2024 11:0	
			RHC VI	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			293, 465	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.0
	the contractor for services rendered in the cost reporting				l
	"NONE" or enter a zero	•			l
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			l
	payment. If none, write "NONE" or enter a zero. (1)				l
	Program to Provider				
3. 01				0	3.0
3. 02					3.0
3. 03				0	3.0
3. 04				l ol	3.0
3. 05				0	3.0
	Provider to Program			_	
3. 50			08/24/2023	13, 546	3.5
3. 51				0	3. 5
3. 52				0	3. 5
3. 53				0	3. 5
3. 54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		-13, 546	1
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			279, 919	
	27)			,	
	TO BE COMPLETED BY CONTRACTOR				ĺ
5.00	List separately each tentative settlement payment after des	k review. Also show date of			5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		1	•	
5. 01				0	5.0
5. 02				0	5.0
5. 03				0	5.0
	Provider to Program				
5. 50				0	5.5
5. 51				0	5.5
5. 52				0	5.5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			5.9
6. 00	Determined net settlement amount (balance due) based on the				6.0
6. 01	SETTLEMENT TO PROVIDER			46, 445	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6.0
	Total Medicare program liability (see instructions)			326, 364	
7. 00			1		<u> </u>
7. 00	Total medicale program trabitity (see thisti detroils)		Contractor	I NPR Date	
7. 00	Total mearcure program trabitity (see thistractions)		Contractor	NPR Date	
7. 00	Total mearcure program trabitity (see thistractions)	0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	