This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 12/29/2023 3:54 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 12/29/2023 Time: 3:54 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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 FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Patrick Gerveler		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	Patrick Gerveler			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-1,491,367	-177,753	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	10,626	-173		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	27,488	-11,228		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	EAST ADAMS RHC I	0		23,959		0	10.00
10.01	48TH AND MAINE RHC II	0		51,969		0	10.01
10.02	MT STERLING RHC III	0		3,745		0	10.02
10.03	MAIN CAMPUS RHC IV	0		46,600		0	10.03
10.04	BLESSING EXPRESS CLINIC V	0		48,382		0	10.04
10.05	BLESSING WALK IN CLINIC VI	0		384		0	10.05
10.06	HANNIBAL MAIN RHC VII	0		50,993		0	10.06
10.07	PALMYRA RHC VIII	0		9,140		0	10.07
10.08	BOWLING GREEN RHC IX	0		0		0	10.08
200.00	TOTAL	0	-1,453,253	46,018	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1005 BROADWAY	PO Box:			1.00
2.00	City: QUINCY	State: IL	Zip Code: 62301	County: ADAMS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	BLESSING HEALTH - 48TH	148629	99914		12/23/2021	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MT STERLING CLINIC	148630	99914		12/13/2021	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	BLESSING HEALTH MAIN CAMPUS	148631	99914		12/23/2021	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	BLESSING EXPRESS CLINIC	148634	99914		05/20/2022	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	BLESSING WALK IN CLINIC	148635	99914		05/17/2022	N	O	N	15.05
15.06	Hospital-Based Health Clinic - RHC VII	BLESSING HANNIBAL MAIN CLINIC	268800	99926		04/23/2023	N	O	N	15.06
15.07	Hospital-Based Health Clinic - RHC VIII	BLESSING PALMYRA CLINIC	268801	99926		07/24/2023	N	O	N	15.07
15.08	Hospital-Based Health Clinic - RHC IX	BLESSING BOWLING GREEN CLINIC	268802	99926		07/24/2023	N	O	N	15.08
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,153	3,776	0	2,737	9,002	191	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.	34	139	0	33	172		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2022	09/30/2023	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/29/2023 3:54 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.03
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1	60.04
60.05	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.04	1	60.05

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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/29/2023 3:54 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	480,202	4,126,703	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00

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		1.00	2.00	
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 12/29/2023 3:54 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/30/2023	Y	11/30/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 12/29/2023 3:54 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALTH.ORG	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 12/29/2023 3:54 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	284	103,660	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		284	103,660	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		309	112,785	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	EAST ADAMS RHC	88.00				0	26.00
26.01	48TH AND MAINE RHC	88.01				0	26.01
26.02	MT STERLING RHC	88.02				0	26.02
26.03	MAIN CAMPUS RHC	88.03				0	26.03
26.04	BLESSING EXPRESS CLINIC	88.04				0	26.04
26.05	BLESSING WALK IN CLINIC	88.05				0	26.05
26.06	HANNIBAL MAIN RHC	88.06				0	26.06
26.07	PALMYRA RHC	88.07				0	26.07
26.08	BOWLING GREEN RHC	88.08				0	26.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		347				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	20,926	1,013	58,470			1.00
2.00	HMO and other (see instructions)	13,522	15,515				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	858	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	20,926	1,013	58,470			7.00
8.00	INTENSIVE CARE UNIT	2,139	103	5,809			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		37	2,065			13.00
14.00	Total (see instructions)	23,065	1,153	66,344	18.25	2,457.02	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,790	378	4,630	0.00	22.98	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,297	0	4,765	0.00	23.89	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	15,193	0	35,457	0.00	38.88	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	23.07	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	EAST ADAMS RHC	1,204	0	5,513	0.00	7.46	26.00
26.01	48TH AND MAINE RHC	2,820	0	11,930	0.00	19.17	26.01
26.02	MT STERLING RHC	243	0	1,954	0.00	6.31	26.02
26.03	MAIN CAMPUS RHC	7,357	0	74,475	0.00	120.70	26.03
26.04	BLESSING EXPRESS CLINIC	656	0	14,991	0.00	15.67	26.04
26.05	BLESSING WALK IN CLINIC	1,084	0	25,408	0.00	18.41	26.05
26.06	HANNIBAL MAIN RHC	7	0	21,610	0.00	24.14	26.06
26.07	PALMYRA RHC	0	0	3,712	0.00	2.84	26.07
26.08	BOWLING GREEN RHC	0	0	620	0.00	0.95	26.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				18.25	2,781.49	27.00
28.00	Observation Bed Days		0	5,148			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			943			30.00
31.00	Employee discount days - IRF			124			31.00
32.00	Labor & delivery days (see instructions)	0	191	621			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,610	725	13,515	1.00
2.00	HMO and other (see instructions)			2,483	2,201		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				14		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4,610	725	13,515	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	179	5	287	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	EAST ADAMS RHC	0.00					26.00
26.01	48TH AND MAINE RHC	0.00					26.01
26.02	MT STERLING RHC	0.00					26.02
26.03	MAIN CAMPUS RHC	0.00					26.03
26.04	BLESSING EXPRESS CLINIC	0.00					26.04
26.05	BLESSING WALK IN CLINIC	0.00					26.05
26.06	HANNIBAL MAIN RHC	0.00					26.06
26.07	PALMYRA RHC	0.00					26.07
26.08	BOWLING GREEN RHC	0.00					26.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	249,274,643	0	249,274,643	5,994,816.19	41.58	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		502,191	0	502,191	3,153.00	159.27	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		53,137,566	0	53,137,566	208,801.45	254.49	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,278,372	0	1,278,372	40,801.68	31.33	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,782,006	-13,856	1,768,150	51,220.12	34.52	9.00
10.00	Excluded area salaries (see instructions)		20,019,493	539,670	20,559,163	483,285.49	42.54	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		14,548,025	0	14,548,025	128,943.00	112.83	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		323,491	0	323,491	1,983.51	163.09	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		37,251,095	0	37,251,095			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		4,530,360	0	4,530,360			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		54,139	0	54,139			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		5,596,229	0	5,596,229			23.00
24.00	Wage-related costs (RHC/FQHC)		2,174,924	0	2,174,924			24.00
25.00	Interns & residents (in an approved program)		314,404	0	314,404			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	4,913,922	0	4,913,922	208,575.63	23.56	26.00
27.00	Administrative & General	5.00	33,112,720	-22,549	33,090,171	970,127.61	34.11	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	4,351,617	0	4,351,617	169,990.60	25.60	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	46,982	0	46,982	2,148.70	21.87	31.00
32.00	Housekeeping	9.00	4,032,283	0	4,032,283	199,393.19	20.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,951,700	-2,447,288	1,504,412	74,395.34	20.22	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	2,447,288	2,447,288	121,021.88	20.22	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	9,959,109	-67,306	9,891,803	256,112.74	38.62	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	5,795,034	0	5,795,034	223,667.03	25.91	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 12/29/2023 3:54 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		194,858,705	0	194,858,705	5,745,213.06	33.92	1.00
2.00	Excluded area salaries (see instructions)		21,801,499	525,814	22,327,313	534,505.61	41.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)		173,057,206	-525,814	172,531,392	5,210,707.45	33.11	3.00
4.00	Subtotal other wages & related costs (see inst.)		14,871,516	0	14,871,516	130,926.51	113.59	4.00
5.00	Subtotal wage-related costs (see inst.)		37,305,234	0	37,305,234	0.00	21.62	5.00
6.00	Total (sum of lines 3 thru 5)		225,233,956	-525,814	224,708,142	5,341,633.96	42.07	6.00
7.00	Total overhead cost (see instructions)		66,163,367	-89,855	66,073,512	2,225,432.72	29.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part IV Date/Time Prepared: 12/29/2023 3:54 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	4,374,025	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	-2,436,393	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	30,937,871	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	282,431	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	624,336	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	486,071	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	15,216,686	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	353,121	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	889,132	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	50,727,280	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part V | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	15,347,152	50,727,280	1.00
2.00	Hospital	14,548,025	37,251,095	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	349,200	390,020	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	446,402	358,769	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	624,885	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	445,630	13.00
14.00	Hospital-Based Health Clinic RHC	0	131,475	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	245,961	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	96,348	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	1,701,141	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	254,342	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	298,325	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	194,084	14.06
14.07	Hospital-Based Health Clinic RHC 7	3,525	37,362	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	22,015	14.08
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	8,675,828	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Home Health Agency I | PPS

						1.00	
0.00	County				ADAMS		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	5,984	0	5,465	11,449	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	709.00	0.00	1,110.00	1,819.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.99	0.00	0.99	4.00
5.00	Other Administrative Personnel			8.85	0.00	8.85	5.00
6.00	Direct Nursing Service			10.82	0.00	10.82	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			8.78	0.00	8.78	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.40	0.00	2.40	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.58	0.00	0.58	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.96	0.00	0.96	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			5.50	0.00	5.50	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99914	20.00
20.01						99926	20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	5,432	358	139	111	6,040	21.00
22.00	Skilled Nursing Visit Charges	923,440	60,860	23,460	18,870	1,026,630	22.00
23.00	Physical Therapy Visits	4,806	434	39	122	5,401	23.00
24.00	Physical Therapy Visit Charges	817,020	73,780	6,630	20,740	918,170	24.00
25.00	Occupational Therapy Visits	1,426	301	9	57	1,793	25.00
26.00	Occupational Therapy Visit Charges	242,420	51,170	1,530	9,690	304,810	26.00
27.00	Speech Pathology Visits	132	55	0	3	190	27.00
28.00	Speech Pathology Visit Charges	22,440	9,350	0	510	32,300	28.00
29.00	Medical Social Service Visits	39	1	0	0	40	29.00
30.00	Medical Social Service Visit Charges	6,630	170	0	0	6,800	30.00
31.00	Home Health Aide Visits	1,483	226	0	20	1,729	31.00
32.00	Home Health Aide Visit Charges	139,402	21,244	0	1,880	162,526	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	13,318	1,375	187	313	15,193	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,151,352	216,574	31,620	51,690	2,451,236	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,371		116	33	1,520	36.00
37.00	Total Number of Outlier Episodes		57		3	60	37.00
38.00	Total Non-Routine Medical Supply Charges	74,735	4,448	1,955	944	82,082	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	102 PRAIRIE MILLS ROAD	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GOLDEN	IL	62339	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			4800 MAINE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	QUINCY		IL	62301	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8630 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			521 EAST MAIN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MT STERLING		IL	62353	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		BROWN				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0015
Component CCN: 14-8630

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
12/29/2023 3:54 pm

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			927 BROADWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	QUINCY		IL	62301	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IV | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8634 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			420 N 34TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	QUINCY		IL	62301	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-0015 Component CCN: 14-8634	Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC V	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8635 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1005 BROADWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	QUINCY		IL	62301	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-8635 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VI | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VII | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			100 MEDICAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HANNIBAL		MO	63401	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARION				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VII | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 26-8801 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VIII | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			6996 COUNTY ROAD 326		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PALMYRA		MO	63461	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARION				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-0015 Component CCN: 26-8801	Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC VIII	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 26-8802 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IX | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			710 BUSINESS 61 SOUTH		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BOWLING GREEN		MO	63334	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PIKE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 26-8802 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IX | Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	18,500	733	816	20,049	11.00
12.00	Hospice Inpatient Respite Care	15	0	0	15	12.00
13.00	Hospice General Inpatient Care	520	40	37	597	13.00
14.00	Total Hospice Days	19,035	773	853	20,661	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	15	0	0	15	15.00
16.00	Hospice General Inpatient Care	520	40	37	597	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 12/29/2023 3:54 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.185237	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	39,978,295	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	14,136,130	5.00
6.00	Medicaid charges	388,797,997	6.00
7.00	Medicaid cost (line 1 times line 6)	72,019,775	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	17,905,350	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	17,905,350	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	17,653,532	3,874,005	21,527,537	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,270,087	3,874,005	7,144,092	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	3,270,087	3,874,005	7,144,092	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	14,463,220	26.00
27.00	Medicare reimbursable bad debts (see instructions)	529,794	27.00
27.01	Medicare allowable bad debts (see instructions)	815,069	27.01
28.00	Non-Medicare bad debt amount (see instructions)	13,648,151	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,813,418	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	9,957,510	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,862,860	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 12/29/2023 3:54 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.163018	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	17,653,532	3,874,005	21,527,537	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,877,843	3,874,005	6,751,848	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	2,877,843	3,874,005	6,751,848	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	14,463,220	26.00
27.00	Medicare reimbursable bad debts (see instructions)	519,619	27.00
27.01	Medicare allowable bad debts (see instructions)	799,415	27.01
28.00	Non-Medicare bad debt amount (see instructions)	13,663,805	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,507,242	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	9,259,090	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,259,090	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		0	0	64,027	64,027	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		10,402,686	10,402,686	122,979	10,525,665	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1,781,021	1,781,021	2,768,598	4,549,619	1.03
1.04	00104	CAP REL COSTS-MOB		0	0	4,029,596	4,029,596	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL		0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST		0	0	0	0	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER		0	0	0	0	1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE		0	0	0	0	1.08
1.09	00109	CAP REL COSTS-HANNIBAL		0	0	0	0	1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,430,936	14,430,936	422,102	14,853,038	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,913,922	53,022,302	57,936,224	0	57,936,224	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,112,720	116,525,448	149,638,168	-2,445,392	147,192,776	5.00
6.00	00600	MAINTENANCE & REPAIRS	4,351,617	9,278,239	13,629,856	0	13,629,856	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,982	1,562,673	1,609,655	0	1,609,655	8.00
9.00	00900	HOUSEKEEPING	4,032,283	2,565,211	6,597,494	250,168	6,847,662	9.00
10.00	01000	DIETARY	3,951,700	5,587,928	9,539,628	-5,909,849	3,629,779	10.00
11.00	01100	CAFETERIA	0	0	0	5,907,892	5,907,892	11.00
13.00	01300	NURSING ADMINISTRATION	9,959,109	2,114,822	12,073,931	-67,306	12,006,625	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,795,034	1,496,467	7,291,501	0	7,291,501	16.00
20.00	02000	NURSING PROGRAM	4,680,801	3,680,072	8,360,873	-1,706,023	6,654,850	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,278,372	0	1,278,372	0	1,278,372	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,962,537	1,962,537	0	1,962,537	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	663,993	663,993	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	180,261	180,261	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	322,517	15,346	337,863	0	337,863	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	209,567	209,567	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,807,509	16,255,692	54,063,201	844,474	54,907,675	30.00
31.00	03100	INTENSIVE CARE UNIT	6,399,414	2,793,107	9,192,521	-367,304	8,825,217	31.00
41.00	04100	SUBPROVIDER - IRF	1,929,839	579,713	2,509,552	-9,777	2,499,775	41.00
43.00	04300	NURSERY	364,027	68,149	432,176	-62,046	370,130	43.00
44.00	04400	SKILLED NURSING FACILITY	1,782,006	670,400	2,452,406	-17,374	2,435,032	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,329,754	29,057,161	40,386,915	-20,303,042	20,083,873	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	776,707	369,015	1,145,722	-184,528	961,194	52.00
53.00	05300	ANESTHESIOLOGY	218,623	958,422	1,177,045	-452,208	724,837	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,664,648	3,837,212	9,501,860	-271,955	9,229,905	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,025,273	379,284	1,404,557	-5,985	1,398,572	55.00
57.00	05700	CT SCAN	653,721	643,723	1,297,444	-81,641	1,215,803	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	337,767	167,604	505,371	-7,114	498,257	58.00
60.00	06000	LABORATORY	3,569,471	10,144,436	13,713,907	-32,616	13,681,291	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	201,369	1,199,399	1,400,768	0	1,400,768	62.00
65.00	06500	RESPIRATORY THERAPY	2,626,027	715,160	3,341,187	-450,252	2,890,935	65.00
66.00	06600	PHYSICAL THERAPY	1,525,328	11,235	1,536,563	0	1,536,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	986,980	3,594	990,574	-1,561	989,013	67.00
68.00	06800	SPEECH PATHOLOGY	234,775	5,047	239,822	-260	239,562	68.00
69.00	06900	ELECTROCARDIOLOGY	2,720,973	10,118,993	12,839,966	-8,728,260	4,111,706	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	506,453	237,217	743,670	-5,504	738,166	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,267,542	1,529,520	2,797,062	14,549,475	17,346,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,635,404	16,635,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,177,651	24,499,307	29,676,958	628	29,677,586	73.00
74.00	07400	RENAL DIALYSIS	0	958,157	958,157	-22	958,135	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	561,067	304,285	865,352	49,250	914,602	88.00
88.01	08801	48TH AND MAINE RHC	1,833,542	113,853	1,947,395	0	1,947,395	88.01
88.02	08802	MT STERLING RHC	428,550	154,277	582,827	-1,260	581,567	88.02
88.03	08803	MAIN CAMPUS RHC	15,743,052	2,558,187	18,301,239	-1,140,043	17,161,196	88.03
88.04	08804	BLESSING EXPRESS CLINIC	1,193,803	201,402	1,395,205	119,269	1,514,474	88.04
88.05	08805	BLESSING WALK IN CLINIC	2,741,814	192,135	2,933,949	-1,917	2,932,032	88.05
88.06	08806	HANNIBAL MAIN RHC	3,385,141	347,954	3,733,095	-511,997	3,221,098	88.06
88.07	08807	PALMYRA RHC	284,382	61,949	346,331	27,002	373,333	88.07
88.08	08808	BOWLING GREEN RHC	116,547	30,353	146,900	-8,877	138,023	88.08
90.00	09000	CLINIC	34,881,915	5,420,817	40,302,732	-947,988	39,354,744	90.00
90.01	09001	OUTPATIENT INFUSION	361,705	52,924	414,629	-3,776	410,853	90.01
90.02	04950	ONCOLOGY	552,715	114,259	666,974	-4,648	662,326	90.02
90.03	04951	HANNIBAL INFUSION	23,115	57	23,172	0	23,172	90.03
91.00	09100	EMERGENCY	13,508,602	2,776,100	16,284,702	-261,477	16,023,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,021,443	36,463	1,057,906	-23	1,057,883	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,088,055	804,607	3,892,662	-14,310	3,878,352	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		3,395,257	3,395,257	-3,395,257	0	113.00
116.00	11600	HOSPICE	2,181,548	715,957	2,897,505	14,070	2,911,575	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,457,910	346,908,071	588,365,981	-542,837	587,823,144	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,397,378	1,604,451	7,001,829	517,802	7,519,631	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	2,108,491	18,907,760	21,016,251	25,035	21,041,286	193.04
193.05	19305	WELLNESS CENTER	310,864	131,392	442,256	0	442,256	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	249,274,643	367,551,674	616,826,317	0	616,826,317	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	15,464	79,491		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-9,908,017	617,648		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	5,514,122	10,063,741		1.03
1.04	00104	CAP REL COSTS-MOB	-2,682,630	1,346,966		1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	800,691	800,691		1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	137,622	137,622		1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	1,097,072	1,097,072		1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE	1,529,311	1,529,311		1.08
1.09	00109	CAP REL COSTS-HANNIBAL	423,756	423,756		1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,062,719	16,915,757		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-48,896,410	9,039,814		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-60,508,836	86,683,940		5.00
6.00	00600	MAINTENANCE & REPAIRS	-943,137	12,686,719		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,946	1,623,601		8.00
9.00	00900	HOUSEKEEPING	-79,600	6,768,062		9.00
10.00	01000	DIETARY	-1,129,657	2,500,122		10.00
11.00	01100	CAFETERIA	-1,996,359	3,911,533		11.00
13.00	01300	NURSING ADMINISTRATION	972,352	12,978,977		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,194,148	9,485,649		16.00
20.00	02000	NURSING PROGRAM	-3,833,388	2,821,462		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,278,372		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,962,537		22.00
23.00	02300	PARAMED ED PRGM	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-364,020	299,973		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-78,860	101,401		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	337,863		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	-50,838	158,729		23.04
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-7,998,613	46,909,062		30.00
31.00	03100	INTENSIVE CARE UNIT	-1,937,000	6,888,217		31.00
41.00	04100	SUBPROVIDER - IRF	-17,473	2,482,302		41.00
43.00	04300	NURSERY	0	370,130		43.00
44.00	04400	SKILLED NURSING FACILITY	-1,036	2,433,996		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-29,024	20,054,849		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	961,194		52.00
53.00	05300	ANESTHESIOLOGY	0	724,837		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,282,353	7,947,552		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,398,572		55.00
57.00	05700	CT SCAN	0	1,215,803		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	498,257		58.00
60.00	06000	LABORATORY	1,112,813	14,794,104		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,400,768		62.00
65.00	06500	RESPIRATORY THERAPY	-5,557	2,885,378		65.00
66.00	06600	PHYSICAL THERAPY	0	1,536,563		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	989,013		67.00
68.00	06800	SPEECH PATHOLOGY	0	239,562		68.00
69.00	06900	ELECTROCARDIOLOGY	-16,381	4,095,325		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-19,185	718,981		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-301,152	17,045,385		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,635,404		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-98,680	29,578,906		73.00
74.00	07400	RENAL DIALYSIS	0	958,135		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC	-81,673	832,929		88.00
88.01	08801	48TH AND MAINE RHC	10,126	1,957,521		88.01
88.02	08802	MT STERLING RHC	-63,464	518,103		88.02
88.03	08803	MAIN CAMPUS RHC	-3,826,526	13,334,670		88.03
88.04	08804	BLESSING EXPRESS CLINIC	12,699	1,527,173		88.04
88.05	08805	BLESSING WALK IN CLINIC	20,194	2,952,226		88.05
88.06	08806	HANNIBAL MAIN RHC	18,366	3,239,464		88.06
88.07	08807	PALMYRA RHC	-5,448	367,885		88.07
88.08	08808	BOWLING GREEN RHC	-316	137,707		88.08
90.00	09000	CLINIC	-29,903,783	9,450,961		90.00
90.01	09001	OUTPATIENT INFUSION	0	410,853		90.01
90.02	04950	ONCOLOGY	0	662,326		90.02
90.03	04951	HANNIBAL INFUSION	0	23,172		90.03
91.00	09100	EMERGENCY	-7,498,153	8,525,072		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	1,057,883		93.99

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	-8,058	3,870,294	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	173,624	3,085,199	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-167,456,602	420,366,542	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,412	7,517,219	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	RENTED SPACE	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	21,041,286	193.04
193.05	19305	WELLNESS CENTER	-51	442,205	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-167,459,065	449,367,252	200.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 12/29/2023 3:54 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	2,447,288	3,460,604	1.00
	0		2,447,288	3,460,604	
	B - RECLASS C-SECTION COSTS				
1.00	OPERATING ROOM	50.00	14,788	0	1.00
	0		14,788	0	
	C - RECLASS PORTION OF HANNIBAL MAIN RHC				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	401,181	110,816	1.00
	0		401,181	110,816	
	D - RECLASS CAPITAL RELATED INSURANCE				
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	64,027	1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	122,979	2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	177,636	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,981	4.00
	0		0	387,623	
	E - RECLASS VOLUNTEER SERVICES				
1.00	HOSPICE	116.00	23,085	3,872	1.00
	0		23,085	3,872	
	F - RECLASS TEACHING FEES				
1.00	ADULTS & PEDIATRICS	30.00	72,724	0	1.00
	TOTALS		72,724	0	
	G - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	2,883,673	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	399,121	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	112,463	3.00
	0		0	3,395,257	
	H - RECLASS RAD AND PT WAGES				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	70,941	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	191,875	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	21,475	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	10,132	0	4.00
	TOTALS		294,423	0	
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,549,475	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,635,404	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	628	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		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	0		0	31,185,507	
	J - RECLASS PRECEPTOR PAY				
1.00	NURSING PROGRAM	20.00	876,574	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 12/29/2023 3:54 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		876,574	0	
	K - RECLASS RENT EXPENSE				
1.00	CAP REL COSTS-MOB	1.04	0	2,064,330	1.00
2.00	CAP REL COSTS-MOB	1.04	0	1,965,266	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
	0		0	4,029,596	
	L - RECLASS LEASEHOLD IMP DEPR				
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,944	1.00
2.00	EAST ADAMS RHC	88.00	0	49,250	2.00
3.00	MT STERLING RHC	88.02	0	69,681	3.00
4.00	BLESSING EXPRESS CLINIC	88.04	0	95,069	4.00
5.00	PALMYRA RHC	88.07	0	48,477	5.00
6.00	BOWLING GREEN RHC	88.08	0	1,255	6.00
7.00	RETAIL PHARMACIES	193.04	0	25,035	7.00
	0		0	292,711	
	M - RECLASS OTHER PARAMEDIC PROGRAMS				
1.00	PARAMED ED PRGM-RESPIRATORY	23.04	176,960	32,607	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	78,479	55,596	2.00
3.00	PARAMED ED PRGM-LABORATORY	23.02	135,875	44,386	3.00
4.00	PARAMED ED PRGM-RADIOLOGY	23.01	462,838	201,155	4.00
5.00	ADULTS & PEDIATRICS	30.00	658,227	683,674	5.00
	0		1,512,379	1,017,418	
	N - RECLASS CONTRACTED HOUSEKEEPING				
1.00	HOUSEKEEPING	9.00	0	250,168	1.00
2.00	BLESSING EXPRESS CLINIC	88.04	0	24,200	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,805	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
	0		0	280,173	
500.00	Grand Total: Increases		5,642,442	44,163,577	500.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 12/29/2023 3:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	2,447,288	3,460,604	0		1.00
	0		2,447,288	3,460,604			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	14,788	0	0		1.00
	0		14,788	0			
	C - RECLASS PORTION OF HANNIBAL MAIN RHC						
1.00	HANNIBAL MAIN RHC	88.06	401,181	110,816	0		1.00
	0		401,181	110,816			
	D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	387,623	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	0		0	387,623			
	E - RECLASS VOLUNTEER SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	23,085	3,872	0		1.00
	0		23,085	3,872			
	F - RECLASS TEACHING FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	72,724	0	0		1.00
	TOTALS		72,724	0			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	3,395,257	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	3,395,257			
	H - RECLASS RAD AND PT WAGES						
1.00	MT STERLING RHC	88.02	70,941	0	0		1.00
2.00	MAIN CAMPUS RHC	88.03	191,875	0	0		2.00
3.00	PALMYRA RHC	88.07	21,475	0	0		3.00
4.00	BOWLING GREEN RHC	88.08	10,132	0	0		4.00
	TOTALS		294,423	0			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	209,546	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	269,021	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	2,102	0		3.00
4.00	NURSERY	43.00	0	24,872	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	3,518	0		5.00
6.00	OPERATING ROOM	50.00	0	20,106,472	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	152,583	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	452,208	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	368,953	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,985	0		10.00
11.00	CT SCAN	57.00	0	81,641	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	7,114	0		12.00
13.00	LABORATORY	60.00	0	32,616	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	405,608	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	1,561	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	260	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	8,728,260	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,448	0		18.00
19.00	RENAL DIALYSIS	74.00	0	22	0		19.00
20.00	CLINIC	90.00	0	164,279	0		20.00
21.00	OUTPATIENT INFUSION	90.01	0	3,776	0		21.00
22.00	ONCOLOGY	90.02	0	4,648	0		22.00
23.00	EMERGENCY	91.00	0	140,583	0		23.00
24.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	0	23	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	5,924	0		25.00
26.00	HOSPICE	116.00	0	4,484	0		26.00
	0		0	31,185,507			
	J - RECLASS PRECEPTOR PAY						
1.00	ADMINISTRATIVE & GENERAL	5.00	5,219	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	67,306	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	360,605	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	98,283	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	7,675	0	0		5.00
6.00	NURSERY	43.00	37,174	0	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	13,856	0	0		7.00
8.00	OPERATING ROOM	50.00	109,659	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	17,157	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	7,773	0	0		10.00
11.00	RESPIRATORY THERAPY	65.00	11,052	0	0		11.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 12/29/2023 3:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
12.00	BLESSING WALK IN CLINIC	88.05	1,917	0	0		12.00
13.00	CLINIC	90.00	1,215	0	0		13.00
14.00	EMERGENCY	91.00	120,894	0	0		14.00
15.00	HOME HEALTH AGENCY	101.00	8,386	0	0		15.00
16.00	HOSPICE	116.00	8,403	0	0		16.00
	0		876,574	0			
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,965,266	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	44,471	10		2.00
3.00	DIETARY	10.00	0	1,957	0		3.00
4.00	OPERATING ROOM	50.00	0	91,945	0		4.00
5.00	OPERATING ROOM	50.00	0	4,706	0		5.00
6.00	OPERATING ROOM	50.00	0	5,048	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	189,652	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	33,592	0		8.00
9.00	MAIN CAMPUS RHC	88.03	0	948,168	0		9.00
10.00	CLINIC	90.00	0	602,833	0		10.00
11.00	CLINIC	90.00	0	83,112	0		11.00
12.00	CLINIC	90.00	0	19,094	0		12.00
13.00	CLINIC	90.00	0	39,752	0		13.00
	0		0	4,029,596			
	L - RECLASS LEASEHOLD IMP DEPR						
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	292,711	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	292,711			
	M - RECLASS OTHER PARAMEDIC PROGRAMS						
1.00	NURSING PROGRAM	20.00	1,512,379	1,017,418	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		1,512,379	1,017,418			
	N - RECLASS CONTRACTED HOUSEKEEPING						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	600	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	189,070	0		2.00
3.00	NURSING PROGRAM	20.00	0	52,800	0		3.00
4.00	CLINIC	90.00	0	973	0		4.00
5.00	CLINIC	90.00	0	1,960	0		5.00
6.00	CLINIC	90.00	0	8,400	0		6.00
7.00	CLINIC	90.00	0	3,589	0		7.00
8.00	CLINIC	90.00	0	22,781	0		8.00
	0		0	280,173			
500.00	Grand Total: Decreases		5,642,442	44,163,577			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	16,273,887	631,241	0	631,241	0	1.00
2.00	Land Improvements	13,396,511	248,159	0	248,159	122,132	2.00
3.00	Buildings and Fixtures	163,668,745	17,135,583	0	17,135,583	3,729,819	3.00
4.00	Building Improvements	3,531,182	756,540	0	756,540	6,948	4.00
5.00	Fixed Equipment	150,283,852	8,441,603	0	8,441,603	942,287	5.00
6.00	Movable Equipment	235,267,367	18,556,063	0	18,556,063	581,284	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	582,421,544	45,769,189	0	45,769,189	5,382,470	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	582,421,544	45,769,189	0	45,769,189	5,382,470	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	16,905,128	0	1.00
2.00	Land Improvements	13,522,538	0	2.00
3.00	Buildings and Fixtures	177,074,509	0	3.00
4.00	Building Improvements	4,280,774	0	4.00
5.00	Fixed Equipment	157,783,168	0	5.00
6.00	Movable Equipment	253,242,146	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	622,808,263	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	622,808,263	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	10,402,686	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,781,021	0	0	0	0	1.03
1.04	CAP REL COSTS-MOB	0	0	0	0	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0	0	1.07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	0	0	0	1.08
1.09	CAP REL COSTS-HANNIBAL	0	0	0	0	0	1.09
2.00	CAP REL COSTS-MVBLE EQUIP	14,430,936	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	26,614,643	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	10,402,686	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,781,021	1.03
1.04	CAP REL COSTS-MOB	0	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	1.07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	1.08
1.09	CAP REL COSTS-HANNIBAL	0	0	1.09
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,430,936	2.00
3.00	Total (sum of lines 1-2)	0	26,614,643	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	41,946	0	41,946	0.000071	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	292,791,951	0	292,791,951	0.494263	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	46,304,332	0	46,304,332	0.078167	0	1.03
1.04	CAP REL COSTS-MOB	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0.000000	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0.000000	0	1.07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	0	0.000000	0	1.08
1.09	CAP REL COSTS-HANNIBAL	0	0	0	0.000000	0	1.09
2.00	CAP REL COSTS-MVBLE EQUIP	253,242,146	0	253,242,146	0.427499	0	2.00
3.00	Total (sum of lines 1-2)	592,380,375	0	592,380,375	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	15,464	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	494,669	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	9,886,105	0	1.03
1.04	CAP REL COSTS-MOB	0	0	0	630,428	716,538	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	608,676	192,015	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	137,622	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	1,097,072	0	1.07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	0	1,529,311	0	1.08
1.09	CAP REL COSTS-HANNIBAL	0	0	0	423,756	0	1.09
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,892,776	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	31,715,879	908,553	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	64,027	0	0	79,491	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	122,979	0	0	617,648	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	177,636	0	0	10,063,741	1.03
1.04	CAP REL COSTS-MOB	0	0	0	0	1,346,966	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	800,691	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	137,622	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0	1,097,072	1.07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	0	0	1,529,311	1.08
1.09	CAP REL COSTS-HANNIBAL	0	0	0	0	423,756	1.09
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,981	0	0	16,915,757	2.00
3.00	Total (sum of lines 1-2)	0	387,623	0	0	33,012,055	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)		0	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)		0	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-OAK STREET MALL (chapter 2)		0	CAP REL COSTS-OAK STREET MALL	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BRCN AT 36TH ST (chapter 2)		0	CAP REL COSTS-BRCN AT 36TH ST	1.06	0	1.06
1.07	Investment income - CAP REL COSTS-SURGERY CENTER (chapter 2)		0	CAP REL COSTS-SURGERY CENTER	1.07	0	1.07
1.08	Investment income - CAP REL COSTS-48TH AND MAINE (chapter 2)		0	CAP REL COSTS-48TH AND MAINE	1.08	0	1.08
1.09	Investment income - CAP REL COSTS-HANNIBAL (chapter 2)		0	CAP REL COSTS-HANNIBAL	1.09	0	1.09
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-269,353	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-79,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-65,035,781			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-21,347,559			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,996,359	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-280,726	NURSING PROGRAM	20.00	0	19.00
20.00	Vending machines	B	-12,560	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES		0	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES		0	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	1.04	0	26.04
26.05	Depreciation - CAP REL COSTS-OAK STREET MALL		0	CAP REL COSTS-OAK STREET MALL	1.05	0	26.05
26.06	Depreciation - CAP REL COSTS-BRCN AT 36TH ST		0	CAP REL COSTS-BRCN AT 36TH ST	1.06	0	26.06
26.07	Depreciation - CAP REL COSTS-SURGERY CENTER		0	CAP REL COSTS-SURGERY CENTER	1.07	0	26.07
26.08	Depreciation - CAP REL COSTS-48TH AND MAINE		0	CAP REL COSTS-48TH AND MAINE	1.08	0	26.08
26.09	Depreciation - CAP REL COSTS-HANNIBAL		0	CAP REL COSTS-HANNIBAL	1.09	0	26.09
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RENTAL INSURANCE EXPENSE	A	-25,767	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CHILD CARE CENTER	B	-2,826,100	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	BOOKKEEPING FEES	B	-169,981	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PRINT SHOP	B	-49,292	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HEALTH PROMOTIONS	B	-74,837	NURSING ADMINISTRATION	13.00	0	33.04
33.05	HOUSEKEEPING SERVICES	B	-22,553	HOUSEKEEPING	9.00	0	33.05
33.06	ADVERTISING	A	-1,515	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	ADVERTISING	A	-658,426	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ADVERTISING	A	-816	DIETARY	10.00	0	33.08
33.09	ADVERTISING	A	-118,196	NURSING PROGRAM	20.00	0	33.09
33.10	ADVERTISING	A	-1,027	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	ADVERTISING	A	-68	EAST ADAMS RHC	88.00	0	33.11
33.12	ADVERTISING	A	-8,058	HOME HEALTH AGENCY	101.00	0	33.12
33.13	RENTAL PROPERTY EXPENSE	A	-30,264	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.13
33.14	REAL ESTATE TAXES ON RENTAL	A	-68,337	MAINTENANCE & REPAIRS	6.00	0	33.14
33.15	RENTAL PROPERTY EXPENSE	A	-19,908	MAINTENANCE & REPAIRS	6.00	0	33.15
33.16	INTEREST INCOME	A	-2,883,673	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.16
33.17	INTEREST INCOME	A	-399,121	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.17
33.18	INTEREST INCOME	A	-112,463	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	DIETARY OUTSIDE SERVICES-SALARIES	A	-38,264	DIETARY	10.00	0	33.19
33.20	DIETARY OUTSIDE SERVICES-BENEFITS	A	-7,840	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	PHYSICIAN RECRUITMENT	A	-560,441	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	LOBBYING EXPENSE	A	-69,404	ADMINISTRATIVE & GENERAL	5.00	0	33.22

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.23	TRANSFER TO PARENT	A	-4,099,157	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	NURSING SCHOOL TUITION	B	-3,416,315	NURSING PROGRAM	20.00	0	33.24
33.25	LAB SCHOOL TUITION	B	-78,860	PARAMED ED PRGM-LABORATORY	23.02	0	33.25
33.26	HIM SCHOOL TUITION	B	-35,687	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	RT SCHOOL TUITION	B	-50,838	PARAMED ED PRGM-RESPIRATORY	23.04	0	33.27
33.28	RADIOLOGY SCHOOL TUITION	B	-364,020	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.28
33.29	MISCELLANEOUS INCOME	B	-1,273	NURSING PROGRAM	20.00	0	33.29
33.30	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	BOOK TO MEDICARE DEPRECIATION	A	40,874	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.31
33.32	GROUNDS FEES	B	14	MAINTENANCE & REPAIRS	6.00	0	33.32
33.33	SELF-FUNDED HEALTH INSURANCE	A	-24,562,431	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.33
33.34	TRAUMA ON-CALL	A	-1,079,319	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	NON-HOSPITAL DEPRECIATION	A	-266,554	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.35
33.36	MISCELLANEOUS INCOME	B	-39,000	EMERGENCY	91.00	0	33.36
33.37	MISCELLANEOUS INCOME	B	-11,322	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	MISCELLANEOUS INCOME	B	-514,056	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MISCELLANOUS INCOME	B	-220	DIETARY	10.00	0	33.39
33.40	MISCELLANEOUS INCOME	B	-733	DRUGS CHARGED TO PATIENTS	73.00	0	33.40
33.41	MISCELLANEOUS INCOME	B	-1,261	RADIOLOGY-DIAGNOSTIC	54.00	0	33.41
33.42	MISCELLANEOUS INCOME	B	-1,900	NURSING ADMINISTRATION	13.00	0	33.42
33.43	MISCELLANEOUS INCOME	B	-6	CLINIC	90.00	0	33.43
33.44	DOCTORS LOUNGE REVENUE	B	-358,046	DIETARY	10.00	0	33.44
33.45	CARE COORDINATION	B	-6,211	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	MISCELLANEOUS INCOME	B	-457,538	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	MISCELLANEOUS INCOME	B	-223,151	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.47
33.48	OUTSIDE CATERING	B	-24,700	DIETARY	10.00	0	33.48
33.49	COFFEE BAR	B	-689,599	DIETARY	10.00	0	33.49
33.50	BPS EXPENSES	A	-14,460,604	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	PHARMACY COVERAGE SALARIES	A	-72,984	DRUGS CHARGED TO PATIENTS	73.00	0	33.51
33.52	PHARMACY COVERAGE BENEFITS	A	-14,955	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.52
33.53	PHARMACY COVERAGE EXPENSES	A	-24,963	DRUGS CHARGED TO PATIENTS	73.00	0	33.53
33.54	INTEREST FROM INSURANCE	B	-96,453	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	OTHER OPERATING EXPENSES	A	-104,038	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	OTHER A&G EXPENSES	A	-56,588	ADMINISTRATIVE & GENERAL	5.00	0	33.56
33.57	NP AND PA WAGES	A	-399,424	ADULTS & PEDIATRICS	30.00	0	33.57
33.58	NP AND PA WAGES	A	-723,887	INTENSIVE CARE UNIT	31.00	0	33.58
33.59	NP AND PA WAGES	A	-98,300	OPERATING ROOM	50.00	0	33.59
33.60	NP AND PA WAGES	A	-1,680,870	CLINIC	90.00	0	33.60
33.61	NP AND PA WAGES	A	-343,032	EMERGENCY	91.00	0	33.61
33.62	NP AND PA BENEFITS	A	-665,005	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.62
33.63	COLLEGE OF NURSING LOBBYING	A	-16,878	NURSING PROGRAM	20.00	0	33.63
33.64	LOBBYING EXPENSES	A	-3,095	SUBPROVIDER - IRF	41.00	0	33.64
33.65	MISCELLANEOUS INCOME	B	-76,809	MAINTENANCE & REPAIRS	6.00	0	33.65
33.66	MISCELLANEOUS INCOME	B	-37,988	EMERGENCY	91.00	0	33.66
33.67	HOSPICE RESPITE AND INPATIENT PMT	A	2,294	HOSPICE	116.00	0	33.67
33.68	HOSPITAL SERVICES TO HOSPICE PTS	A	173,006	HOSPICE	116.00	0	33.68
33.69	EMPLOIYED PHYSICIAN BENEFITS	A	-1,884,010	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.69
33.70	DEPRECIATION ADJUSTMENT	A	15,464	CAP REL COSTS-BUTLER BUILDING	1.01	9	33.70
33.71	DEPRECIATION ADJUSTMENT	A	-9,908,017	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	9	33.71
33.72	DEPRECIATION ADJUSTMENT	A	8,656,246	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.72
33.73	DEPRECIATION ADJUSTMENT	A	630,428	CAP REL COSTS-MOB	1.04	9	33.73
33.74	DEPRECIATION ADJUSTMENT	A	608,676	CAP REL COSTS-OAK STREET MALL	1.05	9	33.74
33.75	DEPRECIATION ADJUSTMENT	A	137,622	CAP REL COSTS-BRCN AT 36TH ST	1.06	9	33.75
33.76	DEPRECIATION ADJUSTMENT	A	1,097,072	CAP REL COSTS-SURGERY CENTER	1.07	9	33.76
33.77	DEPRECIATION ADJUSTMENT	A	1,529,311	CAP REL COSTS-48TH AND MAINE	1.08	9	33.77
33.78	DEPRECIATION ADJUSTMENT	A	423,756	CAP REL COSTS-HANNIBAL	1.09	9	33.78
33.79	DEPRECIATION ADJUSTMENT	A	2,914,484	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.79
33.80	DEPRECIAITON ADJUSTMENT	A	-269,061	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.80
33.81	CONTRACTED HOUSEKEEPING	A	-117	HOUSEKEEPING	9.00	0	33.81

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.82	CONTRACTED HOUSEKEEPING	A	-56,930	HOUSEKEEPING	9.00	0	33.82
33.83	PROVIDER TAX	A	-14,152,759	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.84	COMMUNITY BENEFIT	A	-622,917	ADMINISTRATIVE & GENERAL	5.00	0	33.84
33.85	TUITION FOR SOPHOMORE STUDENTS	B	-357,284	ADULTS & PEDIATRICS	30.00	0	33.85
33.86	COSTS FOR NON-RHC ACTIVITY	A	-3,511,718	MAIN CAMPUS RHC	88.03	0	33.86
33.87	SNU PHYSICIAN	A	-1,036	SKILLED NURSING FACILITY	44.00	0	33.87
33.88	CONTRACTED HOUSEKEEPING	A	-4,803	MAINTENANCE & REPAIRS	6.00	0	33.88
33.89	MISCELLANEOUS INCOME	B	-7,330	MAIN CAMPUS RHC	88.03	0	33.89
33.90	MISCELLANEOUS INCOME	B	-387,939	MAIN CAMPUS RHC	88.03	0	33.90
33.91	MISCELLANEOUS INCOME	B	-88,542	ADMINISTRATIVE & GENERAL	5.00	0	33.91
33.92	EQUIPMENT RENT	B	-106,155	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.92
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-167,459,065				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 12/29/2023 3:54 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED	840,064	1,824,243	1.00
2.00	50.00	OPERATING ROOM	BIO-MED	272	590	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	1,079	2,343	3.00
4.00	88.04	BLESSING EXPRESS CLINIC	BIO-MED	31	68	4.00
4.01	88.05	BLESSING WALK IN CLINIC	BIO-MED	1,168	2,537	4.01
4.02	88.07	PALMYRA RHC	BIO-MED	874	1,898	4.02
4.03	88.08	BOWLING GREEN RHC	BIO-MED	719	1,561	4.03
4.04	90.00	CLINIC	BIO-MED	1,425	3,094	4.04
4.05	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	2,063	4,479	4.05
4.06	193.05	WELLNESS CENTER	BIO-MED	56	122	4.06
4.07	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,563,389	1,549,443	4.07
4.08	60.00	LABORATORY	LAUNDRY	215	213	4.08
4.09	88.02	MT STERLING RHC	LAUNDRY	148	147	4.09
4.10	88.03	MAIN CAMPUS RHC	LAUNDRY	4,659	4,617	4.10
4.11	88.04	BLESSING EXPRESS CLINIC	LAUNDRY	1,578	1,564	4.11
4.12	88.07	PALMYRA RHC	LAUNDRY	40	40	4.12
4.13	90.00	CLINIC	LAUNDRY	2,741	2,717	4.13
4.14	192.00	PHYSICIANS' PRIVATE OFFICES	LAUNDRY	496	492	4.14
4.15	193.05	WELLNESS CENTER	LAUNDRY	1,725	1,710	4.15
4.16	88.00	EAST ADAMS RHC	EAST ADAMS RENT	280	86,582	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	59,872,202	20,628,187	4.17
4.18	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	9,485,649	0	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	2,480,270	4.19
4.20	1.04	CAP REL COSTS-MOB	MOB RENT	716,538	2,064,330	4.20
4.21	1.04	CAP REL COSTS-MOB	MOB RENT	0	1,965,266	4.21
4.22	6.00	MAINTENANCE & REPAIRS	MOB UTILITIES	210,885	0	4.22
4.23	10.00	DIETARY	DIETICIAN COSTS	0	5,452	4.23
4.24	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEIFTS	0	1,114	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	DATA ANALYTICS WAGES	0	1,182,432	4.25
4.26	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES WAGES	0	1,447,390	4.26
4.27	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES WAGES	0	1,306,770	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS WAGES	0	7,287,764	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	PURCHASING WAGES	0	1,009,380	4.29
4.30	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED DEPARTMENTS BENEFITS	0	5,578,721	4.30
4.31	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT WAGES	0	4,067,519	4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	DATA ANALYTICS EXPENSES	0	99,168	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	FISCAL SERVICES EXPENSES	0	160,405	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES EXPENSES	0	1,457,784	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS EXPENSES	0	15,008,096	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	PURCHASING EXPENSES	0	775,213	4.36
4.37	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT EXPENSES	0	5,556	4.37
4.38	16.00	MEDICAL RECORDS & LIBRARY	HIM WAGES	0	5,795,034	4.38
4.39	5.00	ADMINISTRATIVE & GENERAL	PFS WAGES	0	5,329,417	4.39
4.40	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS WAGES	0	4,832,431	4.40
4.41	4.00	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE BENEFITS	0	7,898,616	4.41
4.42	16.00	MEDICAL RECORDS & LIBRARY	HIM EXPENSES	0	1,496,467	4.42
4.43	5.00	ADMINISTRATIVE & GENERAL	PFS EXPENSES	0	4,047,625	4.43
4.44	5.00	ADMINISTRATIVE & GENERAL	PT ACCESS EXPENSES	0	362,372	4.44
4.45	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY WAGES	0	13,616	4.45
4.46	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDY BENEFITS	0	2,790	4.46
4.47	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY EXPENSES	0	1,172	4.47
4.48	30.00	ADULTS & PEDIATRICS	TELEMETRY WAGES	0	9,938	4.48
4.49	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	2,036	4.49
4.50	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER WAGES	0	78,001	4.50
4.51	4.00	EMPLOYEE BENEFITS DEPARTMENT	LOGISTICS MANAGER BENEFITS	0	15,982	4.51
4.52	5.00	ADMINISTRATIVE & GENERAL	OAK STREET MALL	0	358,476	4.52
4.53	1.05	CAP REL COSTS-OAK STREET MAL	OAK STREET MALL	381,045	0	4.53
4.54	1.05	CAP REL COSTS-OAK STREET MAL	BBC RENT FOR HIM, PFS, PA	0	189,030	4.54
4.55	13.00	NURSING ADMINISTRATION	HOME OFFICE	5,122,164	0	4.55
4.56	88.00	EAST ADAMS RHC	HOME OFFICE-EAST ADAMS	4,697	0	4.56
4.57	88.01	48TH AND MAINE RHC	HOME OFFICE-48TH STREET	10,126	0	4.57
4.58	88.02	MT STERLING RHC	HOME OFFICE-MT STERLING	1,662	0	4.58
4.59	88.03	MAIN CAMPUS RHC	HOME OFFICE-MAIN	83,236	0	4.59
4.60	88.04	BLESSING EXPRESS CLINIC	HOME OFFICE-EXPRESS	12,722	0	4.60
4.61	88.05	BLESSING WALK IN CLINIC	HOME OFFICE-WALK-IN	21,563	0	4.61
4.62	88.06	HANNIBAL MAIN RHC	HOME OFFICE-HANNIBAL MAIN	18,366	0	4.62
4.63	88.07	PALMYRA RHC	HOME OFFICE-PALMYRA	1,542	0	4.63
4.64	88.08	BOWLING GREEN RHC	HOME OFFICE-BOWLING GREEN	526	0	4.64
4.65	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE-CHIEFS	1,388,514	0	4.65
4.66	60.00	LABORATORY	MOLECULAR LAB	1,974,253	861,442	4.66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 12/29/2023 3:54 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
4.67	116.00	HOSPICE	RENT	0	850	4.67
4.68	116.00	HOSPICE	RENT	0	826	4.68
4.69	88.02	MT STERLING RHC	MT STERLING RENT	21,597	86,724	4.69
4.70	88.03	MAIN CAMPUS RHC	CPC USE	3,548	6,365	4.70
4.71	90.00	CLINIC	CPC USE	30,176	67,403	4.71
4.72	5.00	ADMINISTRATIVE & GENERAL	RHC DIRECTOR WAGES	0	142,097	4.72
4.73	4.00	EMPLOYEE BENEFITS DEPARTMENT	RHC DIRECTOR BENEFITS	0	34,397	4.73
4.74	5.00	ADMINISTRATIVE & GENERAL	RHC DIRECTOR EXPENSES	0	4,426	4.74
4.75	90.00	CLINIC	BARIATRIC RENT	48,848	78,517	4.75
4.76	88.07	PALMYRA RHC	PALMYRA RENT	7,597	13,563	4.76
4.77	5.00	ADMINISTRATIVE & GENERAL	CHIEF MEDICAL OFFICERS WAGES	0	1,283,073	4.77
4.78	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHIEF MEDICAL OFFICERS BENEF	0	156,074	4.78
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			81,840,478	103,188,037	5.00

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

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

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

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

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	BLESSING FOUND	0.00	7.00
8.00	B		0.00	BLESS CORP SVCS	0.00	8.00
9.00	G		0.00	RIVERCORSS DIAG	0.00	9.00
10.00	G		0.00	ILLINI COMM HOS	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 12/29/2023 3:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-984,179	0		1.00
2.00	-318	0		2.00
3.00	-1,264	0		3.00
4.00	-37	0		4.00
4.01	-1,369	0		4.01
4.02	-1,024	0		4.02
4.03	-842	0		4.03
4.04	-1,669	0		4.04
4.05	-2,416	0		4.05
4.06	-66	0		4.06
4.07	13,946	0		4.07
4.08	2	0		4.08
4.09	1	0		4.09
4.10	42	0		4.10
4.11	14	0		4.11
4.12	0	0		4.12
4.13	24	0		4.13
4.14	4	0		4.14
4.15	15	0		4.15
4.16	-86,302	0		4.16
4.17	39,244,015	0		4.17
4.18	9,485,649	0		4.18
4.19	-2,480,270	0		4.19
4.20	-1,347,792	10		4.20
4.21	-1,965,266	10		4.21
4.22	210,885	0		4.22
4.23	-5,452	0		4.23
4.24	-1,114	0		4.24
4.25	-1,182,432	0		4.25
4.26	-1,447,390	0		4.26
4.27	-1,306,770	0		4.27
4.28	-7,287,764	0		4.28
4.29	-1,009,380	0		4.29
4.30	-5,578,721	0		4.30
4.31	-4,067,519	0		4.31
4.32	-99,168	0		4.32
4.33	-160,405	0		4.33
4.34	-1,457,784	0		4.34
4.35	-15,008,096	0		4.35
4.36	-775,213	0		4.36
4.37	-5,556	0		4.37
4.38	-5,795,034	0		4.38
4.39	-5,329,417	0		4.39
4.40	-4,832,431	0		4.40
4.41	-7,898,616	0		4.41
4.42	-1,496,467	0		4.42
4.43	-4,047,625	0		4.43
4.44	-362,372	0		4.44
4.45	-13,616	0		4.45
4.46	-2,790	0		4.46
4.47	-1,172	0		4.47
4.48	-9,938	0		4.48
4.49	-2,036	0		4.49
4.50	-78,001	0		4.50
4.51	-15,982	0		4.51
4.52	-358,476	0		4.52
4.53	381,045	10		4.53
4.54	-189,030	10		4.54
4.55	5,122,164	0		4.55
4.56	4,697	0		4.56
4.57	10,126	0		4.57
4.58	1,662	0		4.58
4.59	83,236	0		4.59
4.60	12,722	0		4.60
4.61	21,563	0		4.61
4.62	18,366	0		4.62
4.63	1,542	0		4.63
4.64	526	0		4.64
4.65	1,388,514	0		4.65
4.66	1,112,811	0		4.66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 12/29/2023 3:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
4.67	-850	0		4.67
4.68	-826	0		4.68
4.69	-65,127	0		4.69
4.70	-2,817	0		4.70
4.71	-37,227	0		4.71
4.72	-142,097	0		4.72
4.73	-34,397	0		4.73
4.74	-4,426	0		4.74
4.75	-29,669	0		4.75
4.76	-5,966	0		4.76
4.77	-1,283,073	0		4.77
4.78	-156,074	0		4.78
5.00	-21,347,559			5.00

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

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

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6.00	BIO-MED/LAUNDRY		6.00
7.00	FUND RAISING		7.00
8.00	HOME OFFICE		8.00
9.00	LABORATORY		9.00
10.00	HOSPITAL		10.00
100.00			100.00

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C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 12/29/2023 3:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,094,247	3,478,351	615,896	211,500	4,136	1.00
2.00	30.00	ADULTS & PEDIATRICS	7,270,351	7,198,103	72,248	211,500	375	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,237,812	1,189,517	48,295	211,500	240	3.00
4.00	41.00	SUBPROVIDER - IRF	45,900	0	45,900	211,500	310	4.00
5.00	50.00	OPERATING ROOM	-53,072	-86,754	33,682	211,500	187	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,278,801	1,278,801	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	17,250	0	17,250	211,500	115	7.00
8.00	69.00	ELECTROCARDIOLOGY	36,401	0	36,401	246,400	169	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	13,650	0	13,650	211,500	91	9.00
10.00	90.00	CLINIC	28,155,594	28,153,966	1,628	211,500	12	10.00
11.00	91.00	EMERGENCY	7,271,519	6,970,316	301,203	211,500	1,883	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	16,434,796	16,434,796	0	0	0	12.00
200.00			65,803,249	64,617,096	1,186,153		7,518	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	420,560	21,028	1,333	201	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	38,131	1,907	25,466	253	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	24,404	1,220	7,559	295	0	3.00
4.00	41.00	SUBPROVIDER - IRF	31,522	1,576	0	0	0	4.00
5.00	50.00	OPERATING ROOM	19,015	951	3,928	-2,493	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	6,052	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	11,693	585	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	20,020	1,001	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	9,253	463	0	0	0	9.00
10.00	90.00	CLINIC	1,220	61	142,644	8	0	10.00
11.00	91.00	EMERGENCY	191,468	9,573	46,292	1,918	0	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	12.00
200.00			767,286	38,365	233,274	182	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	420,761	195,135	3,673,486		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	38,384	33,864	7,231,967		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	24,699	23,596	1,213,113		3.00
4.00	41.00	SUBPROVIDER - IRF	0	31,522	14,378	14,378		4.00
5.00	50.00	OPERATING ROOM	0	16,522	17,160	-69,594		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,278,801		6.00
7.00	65.00	RESPIRATORY THERAPY	0	11,693	5,557	5,557		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	20,020	16,381	16,381		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	9,253	4,397	4,397		9.00
10.00	90.00	CLINIC	0	1,228	400	28,154,366		10.00
11.00	91.00	EMERGENCY	0	193,386	107,817	7,078,133		11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	16,434,796		12.00
200.00			0	767,468	418,685	65,035,781		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	79,491	0	79,491			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	617,648	0	0	617,648		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	10,063,741	0	0	0	10,063,741	1.03
1.04	00104	CAP REL COSTS-MOB	1,346,966	0	0	0	0	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	800,691	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	137,622	0	0	0	0	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	1,097,072	0	0	0	0	1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE	1,529,311	0	0	0	0	1.08
1.09	00109	CAP REL COSTS-HANNIBAL	423,756	0	0	0	0	1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,915,757					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,039,814	0	0	8,372	655,083	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,683,940	0	13,758	158,893	1,739,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	12,686,719	0	0	104,324	1,106,114	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,623,601	0	0	9,760	21,136	8.00
9.00	00900	HOUSEKEEPING	6,768,062	0	0	20,756	40,308	9.00
10.00	01000	DIETARY	2,500,122	0	0	0	226,289	10.00
11.00	01100	CAFETERIA	3,911,533	0	0	0	90,001	11.00
13.00	01300	NURSING ADMINISTRATION	12,978,977	0	0	23,116	14,338	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,485,649	0	0	1,490	30,119	16.00
20.00	02000	NURSING PROGRAM	2,821,462	0	0	0	32,350	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,278,372	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,962,537	0	0	1,490	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	299,973	0	0	0	10,902	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	101,401	0	0	0	8,359	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	337,863	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	158,729	0	0	0	461	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,909,062	0	0	1,078	2,970,790	30.00
31.00	03100	INTENSIVE CARE UNIT	6,888,217	0	0	50,514	197,181	31.00
41.00	04100	SUBPROVIDER - IRF	2,482,302	0	0	23,568	71,022	41.00
43.00	04300	NURSERY	370,130	0	0	0	53,055	43.00
44.00	04400	SKILLED NURSING FACILITY	2,433,996	0	0	0	174,558	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,054,849	0	0	32,194	419,394	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	961,194	0	0	38,730	0	52.00
53.00	05300	ANESTHESIOLOGY	724,837	0	0	3,194	10,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,947,552	0	0	7,751	228,312	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,398,572	0	0	0	169,144	55.00
57.00	05700	CT SCAN	1,215,803	0	0	3,036	15,379	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	498,257	0	0	0	29,584	58.00
60.00	06000	LABORATORY	14,794,104	0	0	3,250	166,928	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,400,768	0	0	0	5,726	62.00
65.00	06500	RESPIRATORY THERAPY	2,885,378	0	0	4,094	47,373	65.00
66.00	06600	PHYSICAL THERAPY	1,536,563	0	0	0	50,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	989,013	0	0	0	24,423	67.00
68.00	06800	SPEECH PATHOLOGY	239,562	0	0	0	8,270	68.00
69.00	06900	ELECTROCARDIOLOGY	4,095,325	0	0	43,144	68,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718,981	0	0	9,368	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,045,385	0	30,646	0	108,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,635,404	0	35,087	0	124,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,578,906	0	0	2,935	87,249	73.00
74.00	07400	RENAL DIALYSIS	958,135	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	832,929	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	1,957,521	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	518,103	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	13,334,670	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	1,527,173	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	2,952,226	0	0	0	55,182	88.05
88.06	08806	HANNIBAL MAIN RHC	3,239,464	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	367,885	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	137,707	0	0	0	0	88.08
90.00	09000	CLINIC	9,450,961	0	0	0	19,827	90.00
90.01	09001	OUTPATIENT INFUSION	410,853	0	0	0	52,043	90.01
90.02	04950	ONCOLOGY	662,326	0	0	0	25,836	90.02
90.03	04951	HANNIBAL INFUSION	23,172	0	0	0	0	90.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
91.00	09100	EMERGENCY	8,525,072	0	0	31,971	221,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,057,883	0	0	0	48,102	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,870,294	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,085,199	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	420,366,542	0	79,491	583,028	9,428,574	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,336	11,854	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,517,219	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	14,874	193.01
193.02	19302	UNUSED SPACE	0	0	0	14,042	369,627	193.02
193.03	19303	RENTED SPACE	0	0	0	4,242	230,364	193.03
193.04	19304	RETAIL PHARMACIES	21,041,286	0	0	0	8,448	193.04
193.05	19305	WELLNESS CENTER	442,205	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	449,367,252	0	79,491	617,648	10,063,741	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	
			1.04	1.05	1.06	1.07	1.08	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB	1,346,966					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	800,691				1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	137,622			1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	0	1,097,072		1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE	0	0	0	0	1,529,311	1.08
1.09	00109	CAP REL COSTS-HANNIBAL	0	0	0	0	0	1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,929	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	282,285	487,959	2,403	170,060	627,634	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	25,738	0	166,571	27,523	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	338	0	5,719	6,922	9.00
10.00	01000	DIETARY	3,810	0	0	0	22,296	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	48,099	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
20.00	02000	NURSING PROGRAM	0	41,782	100,273	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,965	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	937	3,607	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	621	0	0	0	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,586	31,339	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,293	0	0	754,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,954	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,232	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	28,527	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	108,009	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	483,635	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	350,672	0	0	0	53,596	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	25,302	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	
			1.04	1.05	1.06	1.07	1.08	
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	22,285	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,325,408	722,541	137,622	1,097,072	845,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,558	0	0	0	683,331	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	78,150	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,346,966	800,691	137,622	1,097,072	1,529,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			HANNIBAL	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			1.09	2.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL	423,756					1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP		16,915,757				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,323	9,760,521			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	119,219	7,641,509	611,230	98,538,476	98,538,476	5.00
6.00	00600	MAINTENANCE & REPAIRS	16,279	240,965	251,493	14,625,726	4,107,972	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,296	2,715	1,658,508	465,830	8.00
9.00	00900	HOUSEKEEPING	1,098	285,384	233,038	7,361,625	2,067,682	9.00
10.00	01000	DIETARY	0	148,441	84,733	2,985,691	838,600	10.00
11.00	01100	CAFETERIA	0	0	141,436	4,142,970	1,163,648	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,057,370	336,603	14,458,503	4,061,003	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,274	5,853	0	9,533,385	2,677,670	16.00
20.00	02000	NURSING PROGRAM	0	158,352	233,772	3,387,991	951,595	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	73,881	1,352,253	379,811	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	743	0	1,964,770	551,851	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	23,676	26,749	381,265	107,087	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,388	7,853	125,545	35,262	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	18,639	356,502	100,132	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	2,259	10,227	172,297	48,394	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	214,499	1,921,667	52,064,021	14,623,521	30.00
31.00	03100	INTENSIVE CARE UNIT	0	148,933	271,805	7,556,650	2,122,459	31.00
41.00	04100	SUBPROVIDER - IRF	0	4,990	111,088	2,692,970	756,383	41.00
43.00	04300	NURSERY	0	12,777	18,890	454,852	127,756	43.00
44.00	04400	SKILLED NURSING FACILITY	0	996	102,187	2,711,737	761,654	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,823,229	649,001	24,821,682	6,971,740	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,951	43,042	1,057,917	297,140	52.00
53.00	05300	ANESTHESIOLOGY	0	124,326	12,635	877,030	246,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,819	417,225	270,387	8,963,278	2,517,543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	163,404	59,254	1,790,374	502,868	55.00
57.00	05700	CT SCAN	0	397,357	37,780	1,669,355	468,877	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	141,958	19,521	689,320	193,611	58.00
60.00	06000	LABORATORY	0	249,051	206,290	15,419,623	4,330,956	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11,497	11,638	1,429,629	401,544	62.00
65.00	06500	RESPIRATORY THERAPY	0	214,053	151,127	3,330,552	935,462	65.00
66.00	06600	PHYSICAL THERAPY	0	5,414	88,153	1,680,671	472,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	57,041	1,070,477	300,668	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,786	13,568	264,186	74,203	68.00
69.00	06900	ELECTROCARDIOLOGY	0	491,744	157,253	4,855,647	1,363,820	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	39,178	28,483	796,010	223,578	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,209	68,747	17,334,863	4,868,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	92,835	0	16,887,804	4,743,328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,705	694,655	295,014	30,663,464	8,612,539	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	958,135	269,114	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	138	32,426	865,493	243,094	88.00
88.01	08801	48TH AND MAINE RHC	0	0	105,966	2,171,496	609,915	88.01
88.02	08802	MT STERLING RHC	0	24,765	20,667	563,535	158,282	88.02
88.03	08803	MAIN CAMPUS RHC	0	52,271	898,749	14,769,325	4,148,305	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	32,522	68,993	1,628,688	457,454	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	19,825	158,347	3,185,580	894,743	88.05
88.06	08806	HANNIBAL MAIN RHC	72,010	0	172,452	3,483,926	978,541	88.06
88.07	08807	PALMYRA RHC	0	1,857	15,194	384,936	108,118	88.07
88.08	08808	BOWLING GREEN RHC	0	573	6,150	144,430	40,566	88.08
90.00	09000	CLINIC	88,233	336,456	403,746	10,703,491	3,006,322	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	20,904	483,800	135,886	90.01
90.02	04950	ONCOLOGY	0	0	31,943	720,105	202,258	90.02
90.03	04951	HANNIBAL INFUSION	25,061	0	1,336	49,569	13,923	90.03
91.00	09100	EMERGENCY	0	133,934	357,828	9,296,097	2,611,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS HANNIBAL	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			1.09	2.00	4.00	4A	5.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	14,762	59,032	1,179,779	331,368	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	466	177,983	4,071,028	1,143,442	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	7,880	126,927	3,220,006	904,413	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	342,698	16,565,075	9,285,583	418,007,038	89,730,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	28,190	7,918	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,629	215,502	335,116	8,812,355	2,475,153	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	14,874	4,178	193.01
193.02	19302	UNUSED SPACE	0	0	0	383,669	107,762	193.02
193.03	19303	RENTED SPACE	40,743	0	0	275,349	77,338	193.03
193.04	19304	RETAIL PHARMACIES	686	90,238	121,856	21,262,514	5,972,066	193.04
193.05	19305	WELLNESS CENTER	0	44,942	17,966	583,263	163,823	193.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	423,756	16,915,757	9,760,521	449,367,252	98,538,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	18,733,698					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,877	2,202,215				8.00
9.00	00900	HOUSEKEEPING	174,268	22,295	9,625,870			9.00
10.00	01000	DIETARY	389,339	16,217	226,653	4,456,500		10.00
11.00	01100	CAFETERIA	141,088	0	82,142	0	5,529,848	11.00
13.00	01300	NURSING ADMINISTRATION	231,416	0	134,741	0	275,122	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,730	0	48,769	0	0	16.00
20.00	02000	NURSING PROGRAM	689,842	0	401,566	0	158,246	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,832	0	3,986	0	66,802	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	59,830	0	34,858	0	18,140	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	34,882	0	20,321	0	4,141	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	10,319	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	2,052	0	1,172	0	7,739	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,867,203	764,788	2,833,319	3,545,972	1,496,095	30.00
31.00	03100	INTENSIVE CARE UNIT	540,687	123,421	314,735	345,721	192,788	31.00
41.00	04100	SUBPROVIDER - IRF	219,385	119,750	127,707	281,629	80,949	41.00
43.00	04300	NURSERY	83,170	13,351	48,379	0	11,527	43.00
44.00	04400	SKILLED NURSING FACILITY	273,643	87,793	159,282	283,178	83,855	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,561,460	174,965	908,956	0	519,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,555	60,825	103,322	0	33,306	52.00
53.00	05300	ANESTHESIOLOGY	35,138	0	20,477	0	17,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617,118	154,112	359,206	0	214,335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	265,155	85,907	154,358	0	30,061	55.00
57.00	05700	CT SCAN	38,029	59,008	22,118	0	26,028	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	46,377	13,832	26,964	0	13,632	58.00
60.00	06000	LABORATORY	276,580	217	161,002	0	198,721	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,977	0	5,236	0	11,120	62.00
65.00	06500	RESPIRATORY THERAPY	161,467	0	94,022	0	110,372	65.00
66.00	06600	PHYSICAL THERAPY	79,230	0	46,112	0	57,053	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,286	0	22,275	0	37,651	67.00
68.00	06800	SPEECH PATHOLOGY	12,964	0	7,581	0	8,486	68.00
69.00	06900	ELECTROCARDIOLOGY	304,677	87,474	177,336	0	109,869	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,949	666	25,010	0	24,670	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,516	13,552	105,042	0	39,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,351	15,491	120,126	0	49,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,822	0	95,351	0	173,983	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	123,344	0	71,826	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	1,160,206	0	675,347	0	419,641	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	86,504	0	50,333	0	65,009	88.05
88.06	08806	HANNIBAL MAIN RHC	208,030	0	121,064	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	1,188,419	0	691,838	0	421,203	90.00
90.01	09001	OUTPATIENT INFUSION	81,584	725	47,519	0	18,954	90.01
90.02	04950	ONCOLOGY	40,501	0	23,603	0	25,186	90.02
90.03	04951	HANNIBAL INFUSION	72,398	0	42,126	0	0	90.03
91.00	09100	EMERGENCY	548,731	380,611	319,424	0	277,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	75,406	0	43,924	0	49,653	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	47,706	0	27,745	0	0	101.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			6.00	8.00	9.00	10.00	11.00	
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,724,724	2,195,000	9,006,873	4,456,500	5,358,744	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93,476	7,215	54,397	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	946,557	0	551,001	0	171,104	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	23,317	0	13,599	0	0	193.01
193.02	19302	UNUSED SPACE	643,816	0	0	0	0	193.02
193.03	19303	RENTED SPACE	1,119,286	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	15,226	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	167,296	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,733,698	2,202,215	9,625,870	4,456,500	5,529,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	
			13.00	16.00	20.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	19,160,785					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,343,554				16.00
20.00	02000	NURSING PROGRAM	0	0	5,589,240			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		1,732,064		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			2,594,241	22.00
23.00	02300	PARAMED ED PRGM	0	0				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0				23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0				23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,470,998	9,779,060	4,122,537	1,557,794	2,333,224	30.00
31.00	03100	INTENSIVE CARE UNIT	1,220,447	953,469	291,173	48,409	72,505	31.00
41.00	04100	SUBPROVIDER - IRF	512,436	776,649	51,180	0	0	41.00
43.00	04300	NURSERY	72,961	16,170	84,378	11,618	17,401	43.00
44.00	04400	SKILLED NURSING FACILITY	530,832	780,899	26,051	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,289,697	0	262,356	7,745	11,601	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,861	0	246,910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	110,530	0	0	1,936	2,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,936	2,900	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	3,873	5,800	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	47,030	30,013	44,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,873	5,800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	43,342	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	58,327	24,204	36,253	90.00
90.01	09001	OUTPATIENT INFUSION	120,023	0	44,264	0	0	90.01
90.02	04950	ONCOLOGY	159,405	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,758,326	37,307	240,224	40,663	60,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	
			13.00	16.00	20.00	21.00	22.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	314,312	0	10,374	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	868,017	0	55,330	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	521,940	0	5,764			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,160,785	12,343,554	5,589,240	1,732,064	2,594,241	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,160,785	12,343,554	5,589,240	1,732,064	2,594,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	
			23.00	23.01	23.02	23.03	23.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	0					23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		601,180				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			220,151			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY				466,953		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					231,654	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	601,180	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	220,151	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	231,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	466,953	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	
			23.00	23.01	23.02	23.03	23.04	
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	601,180	220,151	466,953	231,654	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	601,180	220,151	466,953	231,654	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER					1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE					1.08
1.09	00109	CAP REL COSTS-HANNIBAL					1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING PROGRAM					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM					23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					23.04
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	107,458,532	-3,891,018	103,567,514		30.00
31.00	03100	INTENSIVE CARE UNIT	13,782,464	-120,914	13,661,550		31.00
41.00	04100	SUBPROVIDER - IRF	5,619,038	0	5,619,038		41.00
43.00	04300	NURSERY	941,563	-29,019	912,544		43.00
44.00	04400	SKILLED NURSING FACILITY	5,698,924	0	5,698,924		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	38,529,855	-19,346	38,510,509		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,187,836	0	2,187,836		52.00
53.00	05300	ANESTHESIOLOGY	1,311,806	-4,836	1,306,970		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,431,608	-4,836	13,426,772		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,828,723	0	2,828,723		55.00
57.00	05700	CT SCAN	2,283,415	0	2,283,415		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,736	0	983,736		58.00
60.00	06000	LABORATORY	20,616,923	-9,673	20,607,250		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,856,506	0	1,856,506		62.00
65.00	06500	RESPIRATORY THERAPY	4,863,529	0	4,863,529		65.00
66.00	06600	PHYSICAL THERAPY	2,335,121	0	2,335,121		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,469,357	0	1,469,357		67.00
68.00	06800	SPEECH PATHOLOGY	367,420	0	367,420		68.00
69.00	06900	ELECTROCARDIOLOGY	7,020,819	-74,966	6,945,853		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,122,556	-9,673	1,112,883		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,542,609	0	22,542,609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,022,577	0	22,022,577		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,176,112	0	40,176,112		73.00
74.00	07400	RENAL DIALYSIS	1,227,249	0	1,227,249		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	EAST ADAMS RHC	1,108,587	0	1,108,587		88.00
88.01	08801	48TH AND MAINE RHC	2,976,581	0	2,976,581		88.01
88.02	08802	MT STERLING RHC	721,817	0	721,817		88.02
88.03	08803	MAIN CAMPUS RHC	21,172,824	0	21,172,824		88.03
88.04	08804	BLESSING EXPRESS CLINIC	2,086,142	0	2,086,142		88.04
88.05	08805	BLESSING WALK IN CLINIC	4,325,511	0	4,325,511		88.05
88.06	08806	HANNIBAL MAIN RHC	4,791,561	0	4,791,561		88.06
88.07	08807	PALMYRA RHC	493,054	0	493,054		88.07
88.08	08808	BOWLING GREEN RHC	184,996	0	184,996		88.08
90.00	09000	CLINIC	16,130,057	-60,457	16,069,600		90.00
90.01	09001	OUTPATIENT INFUSION	932,755	0	932,755		90.01
90.02	04950	ONCOLOGY	1,171,058	0	1,171,058		90.02
90.03	04951	HANNIBAL INFUSION	178,016	0	178,016		90.03
91.00	09100	EMERGENCY	15,571,066	-101,567	15,469,499		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,004,816	0	2,004,816		93.99
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	6,213,268	0	6,213,268		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	4,652,123	0	4,652,123		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	405,392,510	-4,326,305	401,066,205		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191,196	0	191,196		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,956,170	0	12,956,170		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	DENMAN SERVICES	55,968	0	55,968		193.01
193.02	19302	UNUSED SPACE	1,135,247	0	1,135,247		193.02
193.03	19303	RENTED SPACE	1,471,973	0	1,471,973		193.03
193.04	19304	RETAIL PHARMACIES	27,249,806	0	27,249,806		193.04
193.05	19305	WELLNESS CENTER	914,382	0	914,382		193.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	449,367,252	-4,326,305	445,040,947		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,217	0	0	8,372	655,083	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	455,562	0	13,758	158,893	1,739,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	629	0	0	104,324	1,106,114	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	9,760	21,136	8.00
9.00	00900	HOUSEKEEPING	0	0	0	20,756	40,308	9.00
10.00	01000	DIETARY	490	0	0	0	226,289	10.00
11.00	01100	CAFETERIA	0	0	0	0	90,001	11.00
13.00	01300	NURSING ADMINISTRATION	20,700	0	0	23,116	14,338	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,490	30,119	16.00
20.00	02000	NURSING PROGRAM	417,289	0	0	0	32,350	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1,490	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	10,902	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	8,359	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	0	461	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,682	0	0	1,078	2,970,790	30.00
31.00	03100	INTENSIVE CARE UNIT	27,216	0	0	50,514	197,181	31.00
41.00	04100	SUBPROVIDER - IRF	73,831	0	0	23,568	71,022	41.00
43.00	04300	NURSERY	247	0	0	0	53,055	43.00
44.00	04400	SKILLED NURSING FACILITY	101,810	0	0	0	174,558	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,099,849	0	0	32,194	419,394	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	38,730	0	52.00
53.00	05300	ANESTHESIOLOGY	86,774	0	0	3,194	10,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,533	0	0	7,751	228,312	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	169,144	55.00
57.00	05700	CT SCAN	0	0	0	3,036	15,379	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	29,584	58.00
60.00	06000	LABORATORY	421,522	0	0	3,250	166,928	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	5,726	62.00
65.00	06500	RESPIRATORY THERAPY	54,821	0	0	4,094	47,373	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	50,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	24,423	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	8,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	43,144	68,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,357	0	0	9,368	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	30,646	0	108,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,087	0	124,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,935	87,249	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	49,753	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	91,278	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	166,757	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0	55,182	88.05
88.06	08806	HANNIBAL MAIN RHC	24,551	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	56,074	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	15,824	0	0	0	0	88.08
90.00	09000	CLINIC	74,808	0	0	0	19,827	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	52,043	90.01
90.02	04950	ONCOLOGY	0	0	0	0	25,836	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	31,971	221,990	91.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	48,102	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	220,983	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,761,557	0	79,491	583,028	9,428,574	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,336	11,854	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305,798	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	14,874	193.01
193.02	19302	UNUSED SPACE	0	0	0	14,042	369,627	193.02
193.03	19303	RENTED SPACE	0	0	0	4,242	230,364	193.03
193.04	19304	RETAIL PHARMACIES	38,685	0	0	0	8,448	193.04
193.05	19305	WELLNESS CENTER	34,820	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,140,860	0	79,491	617,648	10,063,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	
			1.04	1.05	1.06	1.07	1.08	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,929	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	282,285	487,959	2,403	170,060	627,634	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	25,738	0	166,571	27,523	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	338	0	5,719	6,922	9.00
10.00	01000	DIETARY	3,810	0	0	0	22,296	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	48,099	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
20.00	02000	NURSING PROGRAM	0	41,782	100,273	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,965	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	937	3,607	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	621	0	0	0	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,586	31,339	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,293	0	0	754,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,954	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,232	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	28,527	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	108,009	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	483,635	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	350,672	0	0	0	53,596	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	25,302	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	
			1.04	1.05	1.06	1.07	1.08	
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	22,285	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,325,408	722,541	137,622	1,097,072	845,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,558	0	0	0	683,331	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	78,150	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,346,966	800,691	137,622	1,097,072	1,529,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			HANNIBAL	MVBLE EQUIP				
			1.09	2.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,323	740,924	740,924		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	119,219	7,641,509	11,698,868	46,398	11,745,266	5.00
6.00	00600	MAINTENANCE & REPAIRS	16,279	240,965	1,688,143	19,091	489,655	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,296	32,192	206	55,525	8.00
9.00	00900	HOUSEKEEPING	1,098	285,384	360,525	17,690	246,460	9.00
10.00	01000	DIETARY	0	148,441	401,326	6,432	99,958	10.00
11.00	01100	CAFETERIA	0	0	90,001	10,736	138,702	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,057,370	1,163,623	25,551	484,056	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,274	5,853	47,736	0	319,168	16.00
20.00	02000	NURSING PROGRAM	0	158,352	750,046	17,745	113,427	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	5,608	45,272	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	743	2,233	0	65,779	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	23,676	54,543	2,030	12,764	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,388	16,291	596	4,203	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	1,415	11,935	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	2,259	3,341	776	5,768	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	214,499	3,392,974	145,885	1,742,920	30.00
31.00	03100	INTENSIVE CARE UNIT	0	148,933	423,844	20,632	252,989	31.00
41.00	04100	SUBPROVIDER - IRF	0	4,990	173,411	8,433	90,158	41.00
43.00	04300	NURSERY	0	12,777	66,079	1,434	15,228	43.00
44.00	04400	SKILLED NURSING FACILITY	0	996	277,364	7,757	90,786	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,823,229	5,217,681	49,265	831,005	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,951	53,681	3,267	35,418	52.00
53.00	05300	ANESTHESIOLOGY	0	124,326	226,332	959	29,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,819	417,225	815,872	20,525	300,082	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	163,404	332,548	4,498	59,940	55.00
57.00	05700	CT SCAN	0	397,357	415,772	2,868	55,888	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	141,958	171,542	1,482	23,078	58.00
60.00	06000	LABORATORY	0	249,051	840,751	15,659	516,234	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11,497	17,223	883	47,863	62.00
65.00	06500	RESPIRATORY THERAPY	0	214,053	348,868	11,472	111,504	65.00
66.00	06600	PHYSICAL THERAPY	0	5,414	55,955	6,692	56,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	24,423	4,330	35,838	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,786	11,056	1,030	8,845	68.00
69.00	06900	ELECTROCARDIOLOGY	0	491,744	603,069	11,937	162,562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	39,178	98,903	2,162	26,650	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,209	220,731	5,219	580,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	92,835	252,400	0	565,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,705	694,655	789,544	22,394	1,026,582	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	32,077	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	138	49,891	2,461	28,976	88.00
88.01	08801	48TH AND MAINE RHC	0	0	108,009	8,044	72,700	88.01
88.02	08802	MT STERLING RHC	0	24,765	116,043	1,569	18,867	88.02
88.03	08803	MAIN CAMPUS RHC	0	52,271	535,906	68,223	494,462	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	32,522	199,279	5,237	54,527	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	19,825	75,007	12,020	106,650	88.05
88.06	08806	HANNIBAL MAIN RHC	72,010	0	96,561	13,091	116,638	88.06
88.07	08807	PALMYRA RHC	0	1,857	57,931	1,153	12,887	88.07
88.08	08808	BOWLING GREEN RHC	0	573	16,397	467	4,835	88.08
90.00	09000	CLINIC	88,233	336,456	923,592	30,648	358,342	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	52,043	1,587	16,197	90.01
90.02	04950	ONCOLOGY	0	0	25,836	2,425	24,108	90.02
90.03	04951	HANNIBAL INFUSION	25,061	0	25,061	101	1,660	90.03
91.00	09100	EMERGENCY	0	133,934	413,197	27,162	311,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00

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		Cost Center Description	CAPITAL RELATED COSTS HANNIBAL	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			1.09	2.00	2A	4.00	5.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	14,762	62,864	4,481	39,498	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	466	22,751	13,511	136,294	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	7,880	228,863	9,635	107,803	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	342,698	16,565,075	34,889,046	704,872	10,695,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28,190	0	944	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,629	215,502	1,265,818	25,438	295,029	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	14,874	0	498	193.01
193.02	19302	UNUSED SPACE	0	0	383,669	0	12,845	193.02
193.03	19303	RENTED SPACE	40,743	0	275,349	0	9,218	193.03
193.04	19304	RETAIL PHARMACIES	686	90,238	138,057	9,250	711,848	193.04
193.05	19305	WELLNESS CENTER	0	44,942	157,912	1,364	19,527	193.05
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	423,756	16,915,757	37,152,915	740,924	11,745,266	202.00

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		Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	2,196,889					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,133	97,056				8.00
9.00	00900	HOUSEKEEPING	20,436	983	646,094			9.00
10.00	01000	DIETARY	45,658	715	15,213	569,302		10.00
11.00	01100	CAFETERIA	16,545	0	5,513	0	261,497	11.00
13.00	01300	NURSING ADMINISTRATION	27,138	0	9,044	0	13,010	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,819	0	3,273	0	0	16.00
20.00	02000	NURSING PROGRAM	80,897	0	26,953	0	7,483	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	801	0	268	0	3,159	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	7,016	0	2,340	0	858	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	4,091	0	1,364	0	196	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	488	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	241	0	79	0	366	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	570,772	33,705	190,173	452,985	70,746	30.00
31.00	03100	INTENSIVE CARE UNIT	63,406	5,439	21,125	44,165	9,117	31.00
41.00	04100	SUBPROVIDER - IRF	25,727	5,278	8,572	35,977	3,828	41.00
43.00	04300	NURSERY	9,753	588	3,247	0	545	43.00
44.00	04400	SKILLED NURSING FACILITY	32,090	3,869	10,691	36,175	3,965	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,111	7,711	61,010	0	24,574	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,822	2,681	6,935	0	1,575	52.00
53.00	05300	ANESTHESIOLOGY	4,121	0	1,374	0	826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,369	6,792	24,110	0	10,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,095	3,786	10,361	0	1,422	55.00
57.00	05700	CT SCAN	4,460	2,601	1,485	0	1,231	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,439	610	1,810	0	645	58.00
60.00	06000	LABORATORY	32,434	10	10,807	0	9,397	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,053	0	351	0	526	62.00
65.00	06500	RESPIRATORY THERAPY	18,935	0	6,311	0	5,219	65.00
66.00	06600	PHYSICAL THERAPY	9,291	0	3,095	0	2,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,490	0	1,495	0	1,780	67.00
68.00	06800	SPEECH PATHOLOGY	1,520	0	509	0	401	68.00
69.00	06900	ELECTROCARDIOLOGY	35,729	3,855	11,903	0	5,196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,037	29	1,679	0	1,167	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,169	597	7,050	0	1,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,199	683	8,063	0	2,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,211	0	6,400	0	8,227	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	14,465	0	4,821	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	136,057	0	45,330	0	19,844	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	10,144	0	3,378	0	3,074	88.05
88.06	08806	HANNIBAL MAIN RHC	24,396	0	8,126	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	139,365	0	46,437	0	19,918	90.00
90.01	09001	OUTPATIENT INFUSION	9,567	32	3,189	0	896	90.01
90.02	04950	ONCOLOGY	4,750	0	1,584	0	1,191	90.02
90.03	04951	HANNIBAL INFUSION	8,490	0	2,828	0	0	90.03
91.00	09100	EMERGENCY	64,349	16,774	21,440	0	13,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	8,843	0	2,948	0	2,348	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,594	0	1,862	0	0	101.00

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		Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			6.00	8.00	9.00	10.00	11.00	
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,844,028	96,738	604,546	569,302	253,406	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,962	318	3,651	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,002	0	36,984	0	8,091	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	2,734	0	913	0	0	193.01
193.02	19302	UNUSED SPACE	75,500	0	0	0	0	193.02
193.03	19303	RENTED SPACE	131,258	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	1,786	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	19,619	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,196,889	97,056	646,094	569,302	261,497	202.00

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		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	
			13.00	16.00	20.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,722,422					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	379,996				16.00
20.00	02000	NURSING PROGRAM	0	0	996,551			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		50,880		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			72,240	22.00
23.00	02300	PARAMED ED PRGM	0	0				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0				23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0				23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	851,377	301,048				30.00
31.00	03100	INTENSIVE CARE UNIT	109,710	29,353				31.00
41.00	04100	SUBPROVIDER - IRF	46,064	23,909				41.00
43.00	04300	NURSERY	6,559	498				43.00
44.00	04400	SKILLED NURSING FACILITY	47,718	24,040				44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	295,721	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,955	0				52.00
53.00	05300	ANESTHESIOLOGY	9,936	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00
57.00	05700	CT SCAN	0	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
60.00	06000	LABORATORY	0	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800	SPEECH PATHOLOGY	0	0				68.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0				88.00
88.01	08801	48TH AND MAINE RHC	0	0				88.01
88.02	08802	MT STERLING RHC	0	0				88.02
88.03	08803	MAIN CAMPUS RHC	0	0				88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0				88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0				88.05
88.06	08806	HANNIBAL MAIN RHC	0	0				88.06
88.07	08807	PALMYRA RHC	0	0				88.07
88.08	08808	BOWLING GREEN RHC	0	0				88.08
90.00	09000	CLINIC	0	0				90.00
90.01	09001	OUTPATIENT INFUSION	10,789	0				90.01
90.02	04950	ONCOLOGY	14,329	0				90.02
90.03	04951	HANNIBAL INFUSION	0	0				90.03
91.00	09100	EMERGENCY	158,061	1,148				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	
			13.00	16.00	20.00	21.00	22.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	28,255	0				93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	78,029	0				101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	46,919	0				116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,722,422	379,996	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
193.00	19300	NONPAID WORKERS	0	0				193.00
193.01	19301	DENMAN SERVICES	0	0				193.01
193.02	19302	UNUSED SPACE	0	0				193.02
193.03	19303	RENTED SPACE	0	0				193.03
193.04	19304	RETAIL PHARMACIES	0	0				193.04
193.05	19305	WELLNESS CENTER	0	0				193.05
200.00		Cross Foot Adjustments			996,551	50,880	72,240	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,722,422	379,996	996,551	50,880	72,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	
			23.00	23.01	23.02	23.03	23.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	0					23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		79,551				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			26,741			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY				13,838		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					10,571	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
74.00	07400	RENAL DIALYSIS						74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC						88.00
88.01	08801	48TH AND MAINE RHC						88.01
88.02	08802	MT STERLING RHC						88.02
88.03	08803	MAIN CAMPUS RHC						88.03
88.04	08804	BLESSING EXPRESS CLINIC						88.04
88.05	08805	BLESSING WALK IN CLINIC						88.05
88.06	08806	HANNIBAL MAIN RHC						88.06
88.07	08807	PALMYRA RHC						88.07
88.08	08808	BOWLING GREEN RHC						88.08
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
90.02	04950	ONCOLOGY						90.02
90.03	04951	HANNIBAL INFUSION						90.03
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM						93.99

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	
			23.00	23.01	23.02	23.03	23.04	
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY						101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.00	19300	NONPAID WORKERS						193.00
193.01	19301	DENMAN SERVICES						193.01
193.02	19302	UNUSED SPACE						193.02
193.03	19303	RENTED SPACE						193.03
193.04	19304	RETAIL PHARMACIES						193.04
193.05	19305	WELLNESS CENTER						193.05
200.00		Cross Foot Adjustments	0	79,551	26,741	13,838	10,571	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	79,551	26,741	13,838	10,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER					1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE					1.08
1.09	00109	CAP REL COSTS-HANNIBAL					1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING PROGRAM					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM					23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY					23.04
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,752,585	0	7,752,585		30.00
31.00	03100	INTENSIVE CARE UNIT	979,780	0	979,780		31.00
41.00	04100	SUBPROVIDER - IRF	421,357	0	421,357		41.00
43.00	04300	NURSERY	103,931	0	103,931		43.00
44.00	04400	SKILLED NURSING FACILITY	534,455	0	534,455		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,670,078	0	6,670,078		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,334	0	143,334		52.00
53.00	05300	ANESTHESIOLOGY	272,910	0	272,910		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,886	0	1,249,886		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	443,650	0	443,650		55.00
57.00	05700	CT SCAN	484,305	0	484,305		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,606	0	204,606		58.00
60.00	06000	LABORATORY	1,425,292	0	1,425,292		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	67,899	0	67,899		62.00
65.00	06500	RESPIRATORY THERAPY	502,309	0	502,309		65.00
66.00	06600	PHYSICAL THERAPY	133,998	0	133,998		66.00
67.00	06700	OCCUPATIONAL THERAPY	72,356	0	72,356		67.00
68.00	06800	SPEECH PATHOLOGY	23,361	0	23,361		68.00
69.00	06900	ELECTROCARDIOLOGY	834,251	0	834,251		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	135,627	0	135,627		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	836,999	0	836,999		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	853,072	0	853,072		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,872,358	0	1,872,358		73.00
74.00	07400	RENAL DIALYSIS	32,077	0	32,077		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	EAST ADAMS RHC	81,328	0	81,328		88.00
88.01	08801	48TH AND MAINE RHC	208,039	0	208,039		88.01
88.02	08802	MT STERLING RHC	136,479	0	136,479		88.02
88.03	08803	MAIN CAMPUS RHC	1,299,822	0	1,299,822		88.03
88.04	08804	BLESSING EXPRESS CLINIC	259,043	0	259,043		88.04
88.05	08805	BLESSING WALK IN CLINIC	210,273	0	210,273		88.05
88.06	08806	HANNIBAL MAIN RHC	258,812	0	258,812		88.06
88.07	08807	PALMYRA RHC	71,971	0	71,971		88.07
88.08	08808	BOWLING GREEN RHC	21,699	0	21,699		88.08
90.00	09000	CLINIC	1,518,302	0	1,518,302		90.00
90.01	09001	OUTPATIENT INFUSION	94,300	0	94,300		90.01
90.02	04950	ONCOLOGY	74,223	0	74,223		90.02
90.03	04951	HANNIBAL INFUSION	38,140	0	38,140		90.03
91.00	09100	EMERGENCY	1,026,490	0	1,026,490		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	149,237	0	149,237		93.99
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	258,041	0	258,041		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	393,220	0	393,220		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,149,895	0	32,149,895		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,065	0	44,065		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,742,362	0	1,742,362		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	DENMAN SERVICES	19,019	0	19,019		193.01
193.02	19302	UNUSED SPACE	472,014	0	472,014		193.02
193.03	19303	RENTED SPACE	415,825	0	415,825		193.03
193.04	19304	RETAIL PHARMACIES	860,941	0	860,941		193.04
193.05	19305	WELLNESS CENTER	198,422	0	198,422		193.05
200.00		Cross Foot Adjustments	1,250,372	0	1,250,372		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	37,152,915	0	37,152,915		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	1,092				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	121,441			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	676,612		1.03
1.04	00104	CAP REL COSTS-MOB	0	0	0	0	138,583	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	0	0	0	1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE	0	0	0	0	0	1.08
1.09	00109	CAP REL COSTS-HANNIBAL	0	0	0	0	0	1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,646	44,043	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	31,241	116,957	29,043	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	20,512	74,367	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,919	1,421	0	8.00
9.00	00900	HOUSEKEEPING	0	0	4,081	2,710	0	9.00
10.00	01000	DIETARY	0	0	0	15,214	392	10.00
11.00	01100	CAFETERIA	0	0	0	6,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,545	964	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	293	2,025	0	16.00
20.00	02000	NURSING PROGRAM	0	0	0	2,175	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	293	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	733	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	562	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	31	0	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	212	199,734	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	9,932	13,257	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,634	4,775	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,736	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	6,330	28,197	9,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,615	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,524	15,350	8,872	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,372	0	55.00
57.00	05700	CT SCAN	0	0	597	1,034	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,989	0	58.00
60.00	06000	LABORATORY	0	0	639	11,223	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	805	3,185	2,935	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,483	4,584	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,842	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	421	0	7,320	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	482	0	8,369	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	577	5,866	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	49,759	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	3,710	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	0	1,333	36,079	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,499	0	90.01
90.02	04950	ONCOLOGY	0	0	0	1,737	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	6,286	14,925	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,234	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,092	114,634	633,908	136,365	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,212	797	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,218	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01
193.02	19302	UNUSED SPACE	0	0	2,761	24,851	0	193.02
193.03	19303	RENTED SPACE	0	0	834	15,488	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	568	0	193.04
193.05	19305	WELLNESS CENTER	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	79,491	617,648	10,063,741	1,346,966	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	72.793956	5.085992	14.873725	9.719562	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	48TH AND MAINE (SQUARE FEET)	HANNIBAL (SQUARE FEET)	
			1.05	1.06	1.07	1.08	1.09	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	73,512					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	32,356				1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER	0	0	33,952			1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE	0	0	0	74,902		1.08
1.09	00109	CAP REL COSTS-HANNIBAL	0	0	0	0	52,503	1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,115	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,800	565	5,263	30,740	14,771	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,363	0	5,155	1,348	2,017	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	31	0	177	339	136	9.00
10.00	01000	DIETARY	0	0	0	1,092	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,416	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,273	16.00
20.00	02000	NURSING PROGRAM	3,836	23,575	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,833	0	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	86	848	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	57	0	0	0	0	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,431	7,368	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	23,357	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	721	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	583	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	5,290	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	8,922	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	0	2,625	10,932	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	3,105	90.03
91.00	09100	EMERGENCY	2,323	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	48TH AND MAINE (SQUARE FEET)	HANNIBAL (SQUARE FEET)	
			1.05	1.06	1.07	1.08	1.09	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,046	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,337	32,356	33,952	41,434	42,460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	33,468	4,910	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	5,048	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	85	193.04
193.05	19305	WELLNESS CENTER	7,175	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	800,691	137,622	1,097,072	1,529,311	423,756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.891977	4.253369	32.312441	20.417492	8.071082	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			2.00	4.00	5A	5.00	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP	17,078,866					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,548	168,887,876				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,715,196	10,576,187	-98,538,476	350,828,776		5.00
6.00	00600	MAINTENANCE & REPAIRS	243,288	4,351,617	0	14,625,726	803,452	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,309	46,982	0	1,658,508	3,340	8.00
9.00	00900	HOUSEKEEPING	288,136	4,032,283	0	7,361,625	7,474	9.00
10.00	01000	DIETARY	149,872	1,466,148	0	2,985,691	16,698	10.00
11.00	01100	CAFETERIA	0	2,447,288	0	4,142,970	6,051	11.00
13.00	01300	NURSING ADMINISTRATION	1,067,565	5,824,284	0	14,458,503	9,925	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,909	0	0	9,533,385	3,591	16.00
20.00	02000	NURSING PROGRAM	159,879	4,044,996	0	3,387,991	29,586	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,278,372	0	1,352,253	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	750	0	0	1,964,770	293	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23,904	462,838	0	381,265	2,566	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	3,421	135,875	0	125,545	1,496	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	322,517	0	356,502	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	2,281	176,960	0	172,297	88	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	216,567	33,251,114	0	52,064,021	208,745	30.00
31.00	03100	INTENSIVE CARE UNIT	150,369	4,703,082	0	7,556,650	23,189	31.00
41.00	04100	SUBPROVIDER - IRF	5,038	1,922,164	0	2,692,970	9,409	41.00
43.00	04300	NURSERY	12,900	326,853	0	454,852	3,567	43.00
44.00	04400	SKILLED NURSING FACILITY	1,006	1,768,150	0	2,711,737	11,736	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,850,451	11,229,758	0	24,821,682	66,968	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,095	744,762	0	1,057,917	7,615	52.00
53.00	05300	ANESTHESIOLOGY	125,525	218,623	0	877,030	1,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,248	4,678,549	0	8,963,278	26,467	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	164,980	1,025,273	0	1,790,374	11,372	55.00
57.00	05700	CT SCAN	401,188	653,721	0	1,669,355	1,631	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,327	337,767	0	689,320	1,989	58.00
60.00	06000	LABORATORY	251,452	3,569,471	0	15,419,623	11,862	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,608	201,369	0	1,429,629	385	62.00
65.00	06500	RESPIRATORY THERAPY	216,117	2,614,975	0	3,330,552	6,925	65.00
66.00	06600	PHYSICAL THERAPY	5,466	1,525,328	0	1,680,671	3,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	986,980	0	1,070,477	1,642	67.00
68.00	06800	SPEECH PATHOLOGY	2,813	234,775	0	264,186	556	68.00
69.00	06900	ELECTROCARDIOLOGY	496,485	2,720,973	0	4,855,647	13,067	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,556	492,837	0	796,010	1,842	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,992	1,189,541	0	17,334,863	7,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,730	0	0	16,887,804	8,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	701,353	5,104,667	0	30,663,464	7,026	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	958,135	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	139	561,067	0	865,493	0	88.00
88.01	08801	48TH AND MAINE RHC	0	1,833,542	0	2,171,496	5,290	88.01
88.02	08802	MT STERLING RHC	25,004	357,609	0	563,535	0	88.02
88.03	08803	MAIN CAMPUS RHC	52,775	15,551,177	0	14,769,325	49,759	88.03
88.04	08804	BLESSING EXPRESS CLINIC	32,836	1,193,803	0	1,628,688	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	20,016	2,739,897	0	3,185,580	3,710	88.05
88.06	08806	HANNIBAL MAIN RHC	0	2,983,960	0	3,483,926	8,922	88.06
88.07	08807	PALMYRA RHC	1,875	262,907	0	384,936	0	88.07
88.08	08808	BOWLING GREEN RHC	579	106,415	0	144,430	0	88.08
90.00	09000	CLINIC	339,700	6,986,076	0	10,703,491	50,969	90.00
90.01	09001	OUTPATIENT INFUSION	0	361,705	0	483,800	3,499	90.01
90.02	04950	ONCOLOGY	0	552,715	0	720,105	1,737	90.02
90.03	04951	HANNIBAL INFUSION	0	23,115	0	49,569	3,105	90.03

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		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			2.00	4.00	5A	5.00	6.00	
91.00	09100	EMERGENCY	135,225	6,191,553	0	9,296,097	23,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	14,904	1,021,443	0	1,179,779	3,234	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	470	3,079,669	0	4,071,028	2,046	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,956	2,196,230	0	3,220,006	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,724,803	160,669,962	-98,538,476	319,468,562	674,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	28,190	4,009	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	217,580	5,798,559	0	8,812,355	40,596	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	14,874	1,000	193.01
193.02	19302	UNUSED SPACE	0	0	0	383,669	27,612	193.02
193.03	19303	RENTED SPACE	0	0	0	275,349	48,004	193.03
193.04	19304	RETAIL PHARMACIES	91,108	2,108,491	0	21,262,514	653	193.04
193.05	19305	WELLNESS CENTER	45,375	310,864	0	583,263	7,175	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,915,757	9,760,521		98,538,476	18,733,698	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.990450	0.057793		0.280873	23.316512	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		740,924		11,745,266	2,196,889	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004387		0.033479	2.734313	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

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		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,503,794					8.00
9.00	00900	HOUSEKEEPING	15,224	123,162				9.00
10.00	01000	DIETARY	11,074	2,900	250,320			10.00
11.00	01100	CAFETERIA	0	1,051	0	407,279		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,724	0	20,263	1,848,825	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	624	0	0	0	16.00
20.00	02000	NURSING PROGRAM	0	5,138	0	11,655	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	51	0	4,920	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	446	0	1,336	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	260	0	305	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	760	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	15	0	570	0	23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	522,239	36,252	199,176	110,189	913,857	30.00
31.00	03100	INTENSIVE CARE UNIT	84,279	4,027	19,419	14,199	117,761	31.00
41.00	04100	SUBPROVIDER - IRF	81,772	1,634	15,819	5,962	49,445	41.00
43.00	04300	NURSERY	9,117	619	0	849	7,040	43.00
44.00	04400	SKILLED NURSING FACILITY	59,950	2,038	15,906	6,176	51,220	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,476	11,630	0	38,273	317,423	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,535	1,322	0	2,453	20,346	52.00
53.00	05300	ANESTHESIOLOGY	0	262	0	1,286	10,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,236	4,596	0	15,786	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	58,662	1,975	0	2,214	0	55.00
57.00	05700	CT SCAN	40,294	283	0	1,917	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,445	345	0	1,004	0	58.00
60.00	06000	LABORATORY	148	2,060	0	14,636	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	67	0	819	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,203	0	8,129	0	65.00
66.00	06600	PHYSICAL THERAPY	0	590	0	4,202	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	285	0	2,773	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	97	0	625	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,732	2,269	0	8,092	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	455	320	0	1,817	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,254	1,344	0	2,927	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,578	1,537	0	3,644	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,220	0	12,814	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	919	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	8,641	0	30,907	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	644	0	4,788	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	1,549	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	8,852	0	31,022	0	90.00
90.01	09001	OUTPATIENT INFUSION	495	608	0	1,396	11,581	90.01
90.02	04950	ONCOLOGY	0	302	0	1,855	15,381	90.02
90.03	04951	HANNIBAL INFUSION	0	539	0	0	0	90.03
91.00	09100	EMERGENCY	259,902	4,087	0	20,457	169,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	562	0	3,657	30,328	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	355	0	0	83,755	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	50,362	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,498,867	115,242	250,320	394,677	1,848,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,927	696	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,050	0	12,602	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	174	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,202,215	9,625,870	4,456,500	5,529,848	19,160,785	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.464439	78.156168	17.803212	13.577543	10.363763	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,056	646,094	569,302	261,497	1,722,422	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.064541	5.245888	2.274297	0.642059	0.931631	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			16.00	20.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,667					16.00
20.00	02000	NURSING PROGRAM	0	24,244				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		21,468			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			21,468		22.00
23.00	02300	PARAMED ED PRGM	0				0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0					23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0					23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177,198	17,882	19,308	19,308	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,277	1,263	600	600	0	31.00
41.00	04100	SUBPROVIDER - IRF	14,073	222	0	0	0	41.00
43.00	04300	NURSERY	293	366	144	144	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,150	113	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,138	96	96	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,071	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	24	24	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	24	24	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	48	48	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	204	372	372	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	48	48	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	188	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	253	300	300	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	192	0	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	676	1,042	504	504	0	91.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			16.00	20.00	21.00	22.00	23.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	45	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	240	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	25			0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,667	24,244	21,468	21,468	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	RENTED SPACE	0	0	0	0	0	193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0	0	193.04
193.05	19305	WELLNESS CENTER	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,343,554	5,589,240	1,732,064	2,594,241	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.187193	230.541165	80.681200	120.842230	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	379,996	996,551	50,880	72,240	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.698936	41.105057	2.370039	3.365008	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0			0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)		
			23.01	23.02	23.03	23.04		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
1.07	00107	CAP REL COSTS-SURGERY CENTER						1.07
1.08	00108	CAP REL COSTS-48TH AND MAINE						1.08
1.09	00109	CAP REL COSTS-HANNIBAL						1.09
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	100					23.01
23.02	02302	PARAMED ED PRGM-LABORATORY		100				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY			100			23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY				100		23.04
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	100	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	100		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0		88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0		88.01
88.02	08802	MT STERLING RHC	0	0	0	0		88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0		88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0		88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	0	0		88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0		88.06
88.07	08807	PALMYRA RHC	0	0	0	0		88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0		88.08
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0		90.01
90.02	04950	ONCOLOGY	0	0	0	0		90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		Cost Center Description	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)		
			23.01	23.02	23.03	23.04		
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	DENMAN SERVICES	0	0	0	0		193.01
193.02	19302	UNUSED SPACE	0	0	0	0		193.02
193.03	19303	RENTED SPACE	0	0	0	0		193.03
193.04	19304	RETAIL PHARMACIES	0	0	0	0		193.04
193.05	19305	WELLNESS CENTER	0	0	0	0		193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	601,180	220,151	466,953	231,654		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6,011.800000	2,201.510000	4,669.530000	2,316.540000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,551	26,741	13,838	10,571		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	795.510000	267.410000	138.380000	105.710000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 12/29/2023 3:54 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,567,514		103,567,514	33,864	103,601,378	30.00
31.00	03100	INTENSIVE CARE UNIT	13,661,550		13,661,550	23,596	13,685,146	31.00
41.00	04100	SUBPROVIDER - IRF	5,619,038		5,619,038	14,378	5,633,416	41.00
43.00	04300	NURSERY	912,544		912,544	0	912,544	43.00
44.00	04400	SKILLED NURSING FACILITY	5,698,924		5,698,924	0	5,698,924	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,510,509		38,510,509	17,160	38,527,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,187,836		2,187,836	0	2,187,836	52.00
53.00	05300	ANESTHESIOLOGY	1,306,970		1,306,970	0	1,306,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,426,772		13,426,772	0	13,426,772	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,828,723		2,828,723	0	2,828,723	55.00
57.00	05700	CT SCAN	2,283,415		2,283,415	0	2,283,415	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,736		983,736	0	983,736	58.00
60.00	06000	LABORATORY	20,607,250		20,607,250	0	20,607,250	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,856,506		1,856,506	0	1,856,506	62.00
65.00	06500	RESPIRATORY THERAPY	4,863,529	0	4,863,529	5,557	4,869,086	65.00
66.00	06600	PHYSICAL THERAPY	2,335,121	0	2,335,121	0	2,335,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,469,357	0	1,469,357	0	1,469,357	67.00
68.00	06800	SPEECH PATHOLOGY	367,420	0	367,420	0	367,420	68.00
69.00	06900	ELECTROCARDIOLOGY	6,945,853		6,945,853	16,381	6,962,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,112,883		1,112,883	4,397	1,117,280	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,542,609		22,542,609	0	22,542,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,022,577		22,022,577	0	22,022,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,176,112		40,176,112	0	40,176,112	73.00
74.00	07400	RENAL DIALYSIS	1,227,249		1,227,249	0	1,227,249	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	1,108,587		1,108,587	0	1,108,587	88.00
88.01	08801	48TH AND MAINE RHC	2,976,581		2,976,581	0	2,976,581	88.01
88.02	08802	MT STERLING RHC	721,817		721,817	0	721,817	88.02
88.03	08803	MAIN CAMPUS RHC	21,172,824		21,172,824	0	21,172,824	88.03
88.04	08804	BLESSING EXPRESS CLINIC	2,086,142		2,086,142	0	2,086,142	88.04
88.05	08805	BLESSING WALK IN CLINIC	4,325,511		4,325,511	0	4,325,511	88.05
88.06	08806	HANNIBAL MAIN RHC	4,791,561		4,791,561	0	4,791,561	88.06
88.07	08807	PALMYRA RHC	493,054		493,054	0	493,054	88.07
88.08	08808	BOWLING GREEN RHC	184,996		184,996	0	184,996	88.08
90.00	09000	CLINIC	16,069,600		16,069,600	400	16,070,000	90.00
90.01	09001	OUTPATIENT INFUSION	932,755		932,755	0	932,755	90.01
90.02	04950	ONCOLOGY	1,171,058		1,171,058	0	1,171,058	90.02
90.03	04951	HANNIBAL INFUSION	178,016		178,016	0	178,016	90.03
91.00	09100	EMERGENCY	15,469,499		15,469,499	107,817	15,577,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,383,467		8,383,467		8,383,467	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,004,816		2,004,816	0	2,004,816	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,213,268		6,213,268		6,213,268	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,652,123		4,652,123		4,652,123	116.00
200.00		Subtotal (see instructions)	409,449,672	0	409,449,672	223,550	409,673,222	200.00
201.00		Less Observation Beds	8,383,467		8,383,467		8,383,467	201.00
202.00		Total (see instructions)	401,066,205	0	401,066,205	223,550	401,289,755	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I | Date/Time Prepared: 12/29/2023 3:54 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	167,219,984		167,219,984			30.00
31.00	03100	INTENSIVE CARE UNIT	61,804,906		61,804,906			31.00
41.00	04100	SUBPROVIDER - IRF	9,141,477		9,141,477			41.00
43.00	04300	NURSERY	4,237,406		4,237,406			43.00
44.00	04400	SKILLED NURSING FACILITY	7,497,957		7,497,957			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,202,145	128,546,973	192,749,118	0.199796	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,915,687	389,989	12,305,676	0.177791	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	21,215,646	33,840,610	55,056,256	0.023739	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,248,552	61,132,747	84,381,299	0.159120	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	991,175	18,320,843	19,312,018	0.146475	0.000000	55.00
57.00	05700	CT SCAN	59,872,257	85,260,553	145,132,810	0.015733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,898,058	8,815,002	20,713,060	0.047494	0.000000	58.00
60.00	06000	LABORATORY	110,824,607	134,466,651	245,291,258	0.084011	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,047,823	3,673,948	10,721,771	0.173153	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	24,296,533	7,182,183	31,478,716	0.154502	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,978,783	466,147	6,444,930	0.362319	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,158,018	448,844	5,606,862	0.262064	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,622,020	236,562	1,858,582	0.197688	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	57,832,932	71,814,124	129,647,056	0.053575	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,004,873	4,003,634	5,008,507	0.222199	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,612,014	98,234,313	182,846,327	0.123287	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,965,542	94,460,571	144,426,113	0.152483	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	161,444,252	267,055,760	428,500,012	0.093760	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,440,193	0	2,440,193	0.502931	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	1,098,603	1,098,603			88.00
88.01	08801	48TH AND MAINE RHC	0	2,550,377	2,550,377			88.01
88.02	08802	MT STERLING RHC	0	373,097	373,097			88.02
88.03	08803	MAIN CAMPUS RHC	0	26,551,995	26,551,995			88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	2,473,655	2,473,655			88.04
88.05	08805	BLESSING WALK IN CLINIC	0	4,207,125	4,207,125			88.05
88.06	08806	HANNIBAL MAIN RHC	0	5,640,357	5,640,357			88.06
88.07	08807	PALMYRA RHC	0	403,369	403,369			88.07
88.08	08808	BOWLING GREEN RHC	0	118,368	118,368			88.08
90.00	09000	CLINIC	61,331	35,358,706	35,420,037	0.453687	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	24,397	2,929,746	2,954,143	0.315745	0.000000	90.01
90.02	04950	ONCOLOGY	14,763	3,105,215	3,119,978	0.375342	0.000000	90.02
90.03	04951	HANNIBAL INFUSION	0	84,833	84,833	2.098429	0.000000	90.03
91.00	09100	EMERGENCY	23,410,107	48,828,263	72,238,370	0.214145	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,577,864	14,095,879	17,673,743	0.474346	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,601	3,255,129	3,256,730	0.615592	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,553,346	6,553,346			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	423,506	6,192,940	6,616,446			116.00
200.00		Subtotal (see instructions)	982,986,409	1,182,170,457	2,165,156,866			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	982,986,409	1,182,170,457	2,165,156,866			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.199885		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791		52.00
53.00	05300	ANESTHESIOLOGY	0.023739		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475		55.00
57.00	05700	CT SCAN	0.015733		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494		58.00
60.00	06000	LABORATORY	0.084011		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153		62.00
65.00	06500	RESPIRATORY THERAPY	0.154679		65.00
66.00	06600	PHYSICAL THERAPY	0.362319		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064		67.00
68.00	06800	SPEECH PATHOLOGY	0.197688		68.00
69.00	06900	ELECTROCARDIOLOGY	0.053701		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.223076		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760		73.00
74.00	07400	RENAL DIALYSIS	0.502931		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	EAST ADAMS RHC			88.00
88.01	08801	48TH AND MAINE RHC			88.01
88.02	08802	MT STERLING RHC			88.02
88.03	08803	MAIN CAMPUS RHC			88.03
88.04	08804	BLESSING EXPRESS CLINIC			88.04
88.05	08805	BLESSING WALK IN CLINIC			88.05
88.06	08806	HANNIBAL MAIN RHC			88.06
88.07	08807	PALMYRA RHC			88.07
88.08	08808	BOWLING GREEN RHC			88.08
90.00	09000	CLINIC	0.453698		90.00
90.01	09001	OUTPATIENT INFUSION	0.315745		90.01
90.02	04950	ONCOLOGY	0.375342		90.02
90.03	04951	HANNIBAL INFUSION	2.098429		90.03
91.00	09100	EMERGENCY	0.215638		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592		93.99
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 12/29/2023 3:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,567,514		103,567,514	33,864	103,601,378	30.00
31.00	03100	INTENSIVE CARE UNIT	13,661,550		13,661,550	23,596	13,685,146	31.00
41.00	04100	SUBPROVIDER - IRF	5,619,038		5,619,038	14,378	5,633,416	41.00
43.00	04300	NURSERY	912,544		912,544	0	912,544	43.00
44.00	04400	SKILLED NURSING FACILITY	5,698,924		5,698,924	0	5,698,924	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,510,509		38,510,509	17,160	38,527,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,187,836		2,187,836	0	2,187,836	52.00
53.00	05300	ANESTHESIOLOGY	1,306,970		1,306,970	0	1,306,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,426,772		13,426,772	0	13,426,772	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,828,723		2,828,723	0	2,828,723	55.00
57.00	05700	CT SCAN	2,283,415		2,283,415	0	2,283,415	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,736		983,736	0	983,736	58.00
60.00	06000	LABORATORY	20,607,250		20,607,250	0	20,607,250	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,856,506		1,856,506	0	1,856,506	62.00
65.00	06500	RESPIRATORY THERAPY	4,863,529	0	4,863,529	5,557	4,869,086	65.00
66.00	06600	PHYSICAL THERAPY	2,335,121	0	2,335,121	0	2,335,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,469,357	0	1,469,357	0	1,469,357	67.00
68.00	06800	SPEECH PATHOLOGY	367,420	0	367,420	0	367,420	68.00
69.00	06900	ELECTROCARDIOLOGY	6,945,853		6,945,853	16,381	6,962,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,112,883		1,112,883	4,397	1,117,280	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,542,609		22,542,609	0	22,542,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,022,577		22,022,577	0	22,022,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,176,112		40,176,112	0	40,176,112	73.00
74.00	07400	RENAL DIALYSIS	1,227,249		1,227,249	0	1,227,249	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	1,108,587		1,108,587	0	1,108,587	88.00
88.01	08801	48TH AND MAINE RHC	2,976,581		2,976,581	0	2,976,581	88.01
88.02	08802	MT STERLING RHC	721,817		721,817	0	721,817	88.02
88.03	08803	MAIN CAMPUS RHC	21,172,824		21,172,824	0	21,172,824	88.03
88.04	08804	BLESSING EXPRESS CLINIC	2,086,142		2,086,142	0	2,086,142	88.04
88.05	08805	BLESSING WALK IN CLINIC	4,325,511		4,325,511	0	4,325,511	88.05
88.06	08806	HANNIBAL MAIN RHC	4,791,561		4,791,561	0	4,791,561	88.06
88.07	08807	PALMYRA RHC	493,054		493,054	0	493,054	88.07
88.08	08808	BOWLING GREEN RHC	184,996		184,996	0	184,996	88.08
90.00	09000	CLINIC	16,069,600		16,069,600	400	16,070,000	90.00
90.01	09001	OUTPATIENT INFUSION	932,755		932,755	0	932,755	90.01
90.02	04950	ONCOLOGY	1,171,058		1,171,058	0	1,171,058	90.02
90.03	04951	HANNIBAL INFUSION	178,016		178,016	0	178,016	90.03
91.00	09100	EMERGENCY	15,469,499		15,469,499	107,817	15,577,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,383,467		8,383,467		8,383,467	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	2,004,816		2,004,816	0	2,004,816	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,213,268		6,213,268		6,213,268	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,652,123		4,652,123		4,652,123	116.00
200.00		Subtotal (see instructions)	409,449,672	0	409,449,672	223,550	409,673,222	200.00
201.00		Less Observation Beds	8,383,467		8,383,467		8,383,467	201.00
202.00		Total (see instructions)	401,066,205	0	401,066,205	223,550	401,289,755	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	167,219,984		167,219,984			30.00
31.00	03100	INTENSIVE CARE UNIT	61,804,906		61,804,906			31.00
41.00	04100	SUBPROVIDER - IRF	9,141,477		9,141,477			41.00
43.00	04300	NURSERY	4,237,406		4,237,406			43.00
44.00	04400	SKILLED NURSING FACILITY	7,497,957		7,497,957			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,202,145	128,546,973	192,749,118	0.199796	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,915,687	389,989	12,305,676	0.177791	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	21,215,646	33,840,610	55,056,256	0.023739	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,248,552	61,132,747	84,381,299	0.159120	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	991,175	18,320,843	19,312,018	0.146475	0.000000	55.00
57.00	05700	CT SCAN	59,872,257	85,260,553	145,132,810	0.015733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,898,058	8,815,002	20,713,060	0.047494	0.000000	58.00
60.00	06000	LABORATORY	110,824,607	134,466,651	245,291,258	0.084011	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,047,823	3,673,948	10,721,771	0.173153	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	24,296,533	7,182,183	31,478,716	0.154502	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,978,783	466,147	6,444,930	0.362319	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,158,018	448,844	5,606,862	0.262064	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,622,020	236,562	1,858,582	0.197688	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	57,832,932	71,814,124	129,647,056	0.053575	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,004,873	4,003,634	5,008,507	0.222199	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,612,014	98,234,313	182,846,327	0.123287	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,965,542	94,460,571	144,426,113	0.152483	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	161,444,252	267,055,760	428,500,012	0.093760	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,440,193	0	2,440,193	0.502931	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	1,098,603	1,098,603	1.009088	0.000000	88.00
88.01	08801	48TH AND MAINE RHC	0	2,550,377	2,550,377	1.167114	0.000000	88.01
88.02	08802	MT STERLING RHC	0	373,097	373,097	1.934663	0.000000	88.02
88.03	08803	MAIN CAMPUS RHC	0	26,551,995	26,551,995	0.797410	0.000000	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	2,473,655	2,473,655	0.843344	0.000000	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	4,207,125	4,207,125	1.028139	0.000000	88.05
88.06	08806	HANNIBAL MAIN RHC	0	5,640,357	5,640,357	0.849514	0.000000	88.06
88.07	08807	PALMYRA RHC	0	403,369	403,369	1.222340	0.000000	88.07
88.08	08808	BOWLING GREEN RHC	0	118,368	118,368	1.562889	0.000000	88.08
90.00	09000	CLINIC	61,331	35,358,706	35,420,037	0.453687	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	24,397	2,929,746	2,954,143	0.315745	0.000000	90.01
90.02	04950	ONCOLOGY	14,763	3,105,215	3,119,978	0.375342	0.000000	90.02
90.03	04951	HANNIBAL INFUSION	0	84,833	84,833	2.098429	0.000000	90.03
91.00	09100	EMERGENCY	23,410,107	48,828,263	72,238,370	0.214145	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,577,864	14,095,879	17,673,743	0.474346	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,601	3,255,129	3,256,730	0.615592	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,553,346	6,553,346			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	423,506	6,192,940	6,616,446			116.00
200.00		Subtotal (see instructions)	982,986,409	1,182,170,457	2,165,156,866			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	982,986,409	1,182,170,457	2,165,156,866			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	EAST ADAMS RHC	0.000000		88.00
88.01	08801	48TH AND MAINE RHC	0.000000		88.01
88.02	08802	MT STERLING RHC	0.000000		88.02
88.03	08803	MAIN CAMPUS RHC	0.000000		88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000		88.04
88.05	08805	BLESSING WALK IN CLINIC	0.000000		88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000		88.06
88.07	08807	PALMYRA RHC	0.000000		88.07
88.08	08808	BOWLING GREEN RHC	0.000000		88.08
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT INFUSION	0.000000		90.01
90.02	04950	ONCOLOGY	0.000000		90.02
90.03	04951	HANNIBAL INFUSION	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,752,585	0	7,752,585	63,618	121.86	30.00
31.00	INTENSIVE CARE UNIT	979,780		979,780	5,809	168.67	31.00
41.00	SUBPROVIDER - IRF	421,357	0	421,357	4,630	91.01	41.00
43.00	NURSERY	103,931		103,931	2,065	50.33	43.00
44.00	SKILLED NURSING FACILITY	534,455		534,455	4,765	112.16	44.00
200.00	Total (lines 30 through 199)	9,792,108		9,792,108	80,887		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	20,926	2,550,042				30.00
31.00	INTENSIVE CARE UNIT	2,139	360,785				31.00
41.00	SUBPROVIDER - IRF	2,790	253,918				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,297	369,792				44.00
200.00	Total (lines 30 through 199)	29,152	3,534,537				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,670,078	192,749,118	0.034605	24,881,630	861,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,334	12,305,676	0.011648	0	0	52.00
53.00	05300	ANESTHESIOLOGY	272,910	55,056,256	0.004957	8,045,492	39,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,886	84,381,299	0.014812	9,617,041	142,448	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	443,650	19,312,018	0.022973	471,510	10,832	55.00
57.00	05700	CT SCAN	484,305	145,132,810	0.003337	24,599,417	82,088	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,606	20,713,060	0.009878	4,807,449	47,488	58.00
60.00	06000	LABORATORY	1,425,292	245,291,258	0.005811	43,225,411	251,183	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	67,899	10,721,771	0.006333	2,655,676	16,818	62.00
65.00	06500	RESPIRATORY THERAPY	502,309	31,478,716	0.015957	10,082,957	160,894	65.00
66.00	06600	PHYSICAL THERAPY	133,998	6,444,930	0.020791	1,463,852	30,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,356	5,606,862	0.012905	1,018,878	13,149	67.00
68.00	06800	SPEECH PATHOLOGY	23,361	1,858,582	0.012569	509,358	6,402	68.00
69.00	06900	ELECTROCARDIOLOGY	834,251	129,647,056	0.006435	22,538,530	145,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	135,627	5,008,507	0.027079	417,125	11,295	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	836,999	182,846,327	0.004578	30,804,380	141,022	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	853,072	144,426,113	0.005907	25,733,011	152,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,872,358	428,500,012	0.004370	59,436,071	259,736	73.00
74.00	07400	RENAL DIALYSIS	32,077	2,440,193	0.013145	1,073,942	14,117	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	81,328	1,098,603	0.074029	0	0	88.00
88.01	08801	48TH AND MAINE RHC	208,039	2,550,377	0.081572	0	0	88.01
88.02	08802	MT STERLING RHC	136,479	373,097	0.365800	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	1,299,822	26,551,995	0.048954	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	259,043	2,473,655	0.104721	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	210,273	4,207,125	0.049980	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	258,812	5,640,357	0.045886	0	0	88.06
88.07	08807	PALMYRA RHC	71,971	403,369	0.178425	0	0	88.07
88.08	08808	BOWLING GREEN RHC	21,699	118,368	0.183318	0	0	88.08
90.00	09000	CLINIC	1,518,302	35,420,037	0.042866	29,301	1,256	90.00
90.01	09001	OUTPATIENT INFUSION	94,300	2,954,143	0.031921	10,579	338	90.01
90.02	04950	ONCOLOGY	74,223	3,119,978	0.023790	9,853	234	90.02
90.03	04951	HANNIBAL INFUSION	38,140	84,833	0.449589	0	0	90.03
91.00	09100	EMERGENCY	1,026,490	72,238,370	0.014210	8,580,782	121,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	627,343	17,673,743	0.035496	958,408	34,020	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	149,237	3,256,730	0.045824	0	0	93.99
200.00		Total (lines 50 through 199)	22,333,869	1,902,085,344		280,970,653	2,543,639	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,122,537	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	291,173	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	51,180	0	0	0	41.00
43.00	04300	NURSERY	0	84,378	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	26,051	0	0		44.00
200.00		Total (lines 30 through 199)	0	4,575,319	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,122,537	63,618	64.80	20,926	30.00
31.00	03100	INTENSIVE CARE UNIT		291,173	5,809	50.12	2,139	31.00
41.00	04100	SUBPROVIDER - IRF	0	51,180	4,630	11.05	2,790	41.00
43.00	04300	NURSERY		84,378	2,065	40.86	0	43.00
44.00	04400	SKILLED NURSING FACILITY		26,051	4,765	5.47	3,297	44.00
200.00		Total (lines 30 through 199)		4,575,319	80,887		29,152	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	1,356,005	30.00
31.00	03100	INTENSIVE CARE UNIT	107,207	31.00
41.00	04100	SUBPROVIDER - IRF	30,830	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	18,035	44.00
200.00		Total (lines 30 through 199)	1,512,077	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	262,356	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	246,910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	601,180	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	220,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	231,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	47,030	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	466,953	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	43,342	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	58,327	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	44,264	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	240,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		333,595		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	10,374	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	1,286,422	0	1,519,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	262,356	262,356	192,749,118	0.001361	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	246,910	246,910	12,305,676	0.020065	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	55,056,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	601,180	601,180	84,381,299	0.007125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	19,312,018	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	145,132,810	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,713,060	0.000000	58.00
60.00	06000	LABORATORY	0	220,151	220,151	245,291,258	0.000898	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,721,771	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	231,654	231,654	31,478,716	0.007359	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,444,930	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,606,862	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,858,582	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,030	47,030	129,647,056	0.000363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,008,507	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	182,846,327	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,426,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	466,953	466,953	428,500,012	0.001090	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,440,193	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	1,098,603	0.000000	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	2,550,377	0.000000	88.01
88.02	08802	MT STERLING RHC	0	0	0	373,097	0.000000	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	26,551,995	0.000000	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	2,473,655	0.000000	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	43,342	43,342	4,207,125	0.010302	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	5,640,357	0.000000	88.06
88.07	08807	PALMYRA RHC	0	0	0	403,369	0.000000	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	118,368	0.000000	88.08
90.00	09000	CLINIC	0	58,327	58,327	35,420,037	0.001647	90.00
90.01	09001	OUTPATIENT INFUSION	0	44,264	44,264	2,954,143	0.014984	90.01
90.02	04950	ONCOLOGY	0	0	0	3,119,978	0.000000	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	84,833	0.000000	90.03
91.00	09100	EMERGENCY	0	240,224	240,224	72,238,370	0.003325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	333,595	333,595	17,673,743	0.018875	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	10,374	10,374	3,256,730	0.003185	93.99
200.00		Total (lines 50 through 199)	0	2,806,360	2,806,360	1,902,085,344		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001361	24,881,630	33,864	34,144,602	46,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.020065	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	8,045,492	0	8,816,943	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007125	9,617,041	68,521	14,322,145	102,045	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	471,510	0	9,599,573	0	55.00
57.00	05700	CT SCAN	0.000000	24,599,417	0	19,042,236	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,807,449	0	1,951,722	0	58.00
60.00	06000	LABORATORY	0.000898	43,225,411	38,816	10,943,239	9,827	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,655,676	0	1,183,203	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.007359	10,082,957	74,200	2,225,881	16,380	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,463,852	0	17,825	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,018,878	0	12,407	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	509,358	0	6,620	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000363	22,538,530	8,181	26,864,172	9,752	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	417,125	0	755,526	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	30,804,380	0	31,131,065	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	25,733,011	0	32,433,098	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001090	59,436,071	64,785	76,794,287	83,706	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,073,942	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0.000000	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0.000000	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.010302	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0.000000	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000	0	0	0	0	88.08
90.00	09000	CLINIC	0.001647	29,301	48	6,853,188	11,287	90.00
90.01	09001	OUTPATIENT INFUSION	0.014984	10,579	159	1,030,434	15,440	90.01
90.02	04950	ONCOLOGY	0.000000	9,853	0	978,007	0	90.02
90.03	04951	HANNIBAL INFUSION	0.000000	0	0	39,130	0	90.03
91.00	09100	EMERGENCY	0.003325	8,580,782	28,531	7,965,271	26,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.018875	958,408	18,090	2,401,654	45,331	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.003185	0	0	156,101	497	93.99
200.00		Total (lines 50 through 199)		280,970,653	335,195	289,668,329	367,221	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.199796	34,144,602	0	0	6,821,955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	8,816,943	0	0	209,305	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	14,322,145	0	0	2,278,940	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	9,599,573	0	0	1,406,097	55.00
57.00	05700	CT SCAN	0.015733	19,042,236	0	0	299,591	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	1,951,722	0	0	92,695	58.00
60.00	06000	LABORATORY	0.084011	10,943,239	0	0	919,352	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	1,183,203	0	0	204,875	62.00
65.00	06500	RESPIRATORY THERAPY	0.154502	2,225,881	0	0	343,903	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	17,825	0	0	6,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	12,407	0	0	3,251	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	6,620	0	0	1,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053575	26,864,172	0	0	1,439,248	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.222199	755,526	0	0	167,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	31,131,065	0	0	3,838,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	32,433,098	0	0	4,945,496	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	76,794,287	0	103,951	7,200,232	73.00
74.00	07400	RENAL DIALYSIS	0.502931	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC						88.00
88.01	08801	48TH AND MAINE RHC						88.01
88.02	08802	MT STERLING RHC						88.02
88.03	08803	MAIN CAMPUS RHC						88.03
88.04	08804	BLESSING EXPRESS CLINIC						88.04
88.05	08805	BLESSING WALK IN CLINIC						88.05
88.06	08806	HANNIBAL MAIN RHC						88.06
88.07	08807	PALMYRA RHC						88.07
88.08	08808	BOWLING GREEN RHC						88.08
90.00	09000	CLINIC	0.453687	6,853,188	0	0	3,109,202	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	1,030,434	0	0	325,354	90.01
90.02	04950	ONCOLOGY	0.375342	978,007	0	0	367,087	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	39,130	0	0	82,112	90.03
91.00	09100	EMERGENCY	0.214145	7,965,271	0	0	1,705,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	2,401,654	0	0	1,139,215	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	156,101	0	0	96,095	93.99
200.00		Subtotal (see instructions)		289,668,329	0	103,951	37,003,428	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		289,668,329	0	103,951	37,003,428	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,746		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC				88.00
88.01	08801	48TH AND MAINE RHC				88.01
88.02	08802	MT STERLING RHC				88.02
88.03	08803	MAIN CAMPUS RHC				88.03
88.04	08804	BLESSING EXPRESS CLINIC				88.04
88.05	08805	BLESSING WALK IN CLINIC				88.05
88.06	08806	HANNIBAL MAIN RHC				88.06
88.07	08807	PALMYRA RHC				88.07
88.08	08808	BOWLING GREEN RHC				88.08
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
90.02	04950	ONCOLOGY	0	0		90.02
90.03	04951	HANNIBAL INFUSION	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	9,746		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,746		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,670,078	192,749,118	0.034605	51,557	1,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,334	12,305,676	0.011648	0	0	52.00
53.00	05300	ANESTHESIOLOGY	272,910	55,056,256	0.004957	2,662	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,886	84,381,299	0.014812	185,665	2,750	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	443,650	19,312,018	0.022973	0	0	55.00
57.00	05700	CT SCAN	484,305	145,132,810	0.003337	98,098	327	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,606	20,713,060	0.009878	43,949	434	58.00
60.00	06000	LABORATORY	1,425,292	245,291,258	0.005811	808,471	4,698	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	67,899	10,721,771	0.006333	27,999	177	62.00
65.00	06500	RESPIRATORY THERAPY	502,309	31,478,716	0.015957	195,180	3,114	65.00
66.00	06600	PHYSICAL THERAPY	133,998	6,444,930	0.020791	1,230,811	25,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,356	5,606,862	0.012905	1,233,256	15,915	67.00
68.00	06800	SPEECH PATHOLOGY	23,361	1,858,582	0.012569	273,368	3,436	68.00
69.00	06900	ELECTROCARDIOLOGY	834,251	129,647,056	0.006435	15,875	102	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	135,627	5,008,507	0.027079	4,009	109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	836,999	182,846,327	0.004578	82,527	378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	853,072	144,426,113	0.005907	10,523	62	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,872,358	428,500,012	0.004370	1,456,074	6,363	73.00
74.00	07400	RENAL DIALYSIS	32,077	2,440,193	0.013145	13,999	184	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	81,328	1,098,603	0.074029	0	0	88.00
88.01	08801	48TH AND MAINE RHC	208,039	2,550,377	0.081572	0	0	88.01
88.02	08802	MT STERLING RHC	136,479	373,097	0.365800	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	1,299,822	26,551,995	0.048954	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	259,043	2,473,655	0.104721	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	210,273	4,207,125	0.049980	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	258,812	5,640,357	0.045886	0	0	88.06
88.07	08807	PALMYRA RHC	71,971	403,369	0.178425	0	0	88.07
88.08	08808	BOWLING GREEN RHC	21,699	118,368	0.183318	0	0	88.08
90.00	09000	CLINIC	1,518,302	35,420,037	0.042866	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	94,300	2,954,143	0.031921	0	0	90.01
90.02	04950	ONCOLOGY	74,223	3,119,978	0.023790	0	0	90.02
90.03	04951	HANNIBAL INFUSION	38,140	84,833	0.449589	0	0	90.03
91.00	09100	EMERGENCY	1,026,490	72,238,370	0.014210	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	17,673,743	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	149,237	3,256,730	0.045824	0	0	93.99
200.00		Total (lines 50 through 199)	21,706,526	1,902,085,344		5,734,023	65,436	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	262,356	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	246,910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	601,180	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	220,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	231,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	47,030	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	466,953	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	43,342	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	58,327	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	44,264	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	240,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	10,374	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	952,827	0	1,519,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	262,356	262,356	192,749,118	0.001361	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	246,910	246,910	12,305,676	0.020065	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	55,056,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	601,180	601,180	84,381,299	0.007125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	19,312,018	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	145,132,810	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,713,060	0.000000	58.00
60.00	06000	LABORATORY	0	220,151	220,151	245,291,258	0.000898	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,721,771	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	231,654	231,654	31,478,716	0.007359	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,444,930	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,606,862	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,858,582	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,030	47,030	129,647,056	0.000363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,008,507	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	182,846,327	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,426,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	466,953	466,953	428,500,012	0.001090	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,440,193	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	1,098,603	0.000000	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	2,550,377	0.000000	88.01
88.02	08802	MT STERLING RHC	0	0	0	373,097	0.000000	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	26,551,995	0.000000	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	2,473,655	0.000000	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	43,342	43,342	4,207,125	0.010302	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	5,640,357	0.000000	88.06
88.07	08807	PALMYRA RHC	0	0	0	403,369	0.000000	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	118,368	0.000000	88.08
90.00	09000	CLINIC	0	58,327	58,327	35,420,037	0.001647	90.00
90.01	09001	OUTPATIENT INFUSION	0	44,264	44,264	2,954,143	0.014984	90.01
90.02	04950	ONCOLOGY	0	0	0	3,119,978	0.000000	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	84,833	0.000000	90.03
91.00	09100	EMERGENCY	0	240,224	240,224	72,238,370	0.003325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,673,743	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	10,374	10,374	3,256,730	0.003185	93.99
200.00		Total (lines 50 through 199)	0	2,472,765	2,472,765	1,902,085,344		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001361	51,557	70	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.020065	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,662	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007125	185,665	1,323	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	98,098	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	43,949	0	0	0	58.00
60.00	06000	LABORATORY	0.000898	808,471	726	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	27,999	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.007359	195,180	1,436	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,230,811	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,233,256	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	273,368	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000363	15,875	6	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,009	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	82,527	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,523	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001090	1,456,074	1,587	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	13,999	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0.000000	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0.000000	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.010302	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0.000000	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000	0	0	0	0	88.08
90.00	09000	CLINIC	0.001647	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.014984	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.003325	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.003185	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		5,734,023	5,148	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.199796	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	0	0	0	0	55.00
57.00	05700	CT SCAN	0.015733	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	0	0	0	0	58.00
60.00	06000	LABORATORY	0.084011	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.154502	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053575	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.222199	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	0	0	462	0	73.00
74.00	07400	RENAL DIALYSIS	0.502931	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC						88.00
88.01	08801	48TH AND MAINE RHC						88.01
88.02	08802	MT STERLING RHC						88.02
88.03	08803	MAIN CAMPUS RHC						88.03
88.04	08804	BLESSING EXPRESS CLINIC						88.04
88.05	08805	BLESSING WALK IN CLINIC						88.05
88.06	08806	HANNIBAL MAIN RHC						88.06
88.07	08807	PALMYRA RHC						88.07
88.08	08808	BOWLING GREEN RHC						88.08
90.00	09000	CLINIC	0.453687	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0.375342	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.214145	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	462	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	462	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC				88.00
88.01	08801	48TH AND MAINE RHC				88.01
88.02	08802	MT STERLING RHC				88.02
88.03	08803	MAIN CAMPUS RHC				88.03
88.04	08804	BLESSING EXPRESS CLINIC				88.04
88.05	08805	BLESSING WALK IN CLINIC				88.05
88.06	08806	HANNIBAL MAIN RHC				88.06
88.07	08807	PALMYRA RHC				88.07
88.08	08808	BOWLING GREEN RHC				88.08
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
90.02	04950	ONCOLOGY	0	0		90.02
90.03	04951	HANNIBAL INFUSION	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	43		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	43		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	262,356	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	246,910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	601,180	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	220,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	231,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	47,030	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	466,953	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	0	43,342	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	0	0	88.08
90.00	09000	CLINIC	0	0	58,327	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	44,264	0	0	90.01
90.02	04950	ONCOLOGY	0	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	240,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	10,374	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	952,827	0	1,519,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	262,356	262,356	192,749,118	0.001361	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	246,910	246,910	12,305,676	0.020065	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	55,056,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	601,180	601,180	84,381,299	0.007125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	19,312,018	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	145,132,810	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,713,060	0.000000	58.00
60.00	06000	LABORATORY	0	220,151	220,151	245,291,258	0.000898	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,721,771	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	231,654	231,654	31,478,716	0.007359	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,444,930	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,606,862	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,858,582	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,030	47,030	129,647,056	0.000363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,008,507	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	182,846,327	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,426,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	466,953	466,953	428,500,012	0.001090	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,440,193	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0	0	0	1,098,603	0.000000	88.00
88.01	08801	48TH AND MAINE RHC	0	0	0	2,550,377	0.000000	88.01
88.02	08802	MT STERLING RHC	0	0	0	373,097	0.000000	88.02
88.03	08803	MAIN CAMPUS RHC	0	0	0	26,551,995	0.000000	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0	0	0	2,473,655	0.000000	88.04
88.05	08805	BLESSING WALK IN CLINIC	0	43,342	43,342	4,207,125	0.010302	88.05
88.06	08806	HANNIBAL MAIN RHC	0	0	0	5,640,357	0.000000	88.06
88.07	08807	PALMYRA RHC	0	0	0	403,369	0.000000	88.07
88.08	08808	BOWLING GREEN RHC	0	0	0	118,368	0.000000	88.08
90.00	09000	CLINIC	0	58,327	58,327	35,420,037	0.001647	90.00
90.01	09001	OUTPATIENT INFUSION	0	44,264	44,264	2,954,143	0.014984	90.01
90.02	04950	ONCOLOGY	0	0	0	3,119,978	0.000000	90.02
90.03	04951	HANNIBAL INFUSION	0	0	0	84,833	0.000000	90.03
91.00	09100	EMERGENCY	0	240,224	240,224	72,238,370	0.003325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,673,743	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	10,374	10,374	3,256,730	0.003185	93.99
200.00		Total (lines 50 through 199)	0	2,472,765	2,472,765	1,902,085,344		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001361	78,390	107	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.020065	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007125	196,955	1,403	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000898	1,339,979	1,203	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	44,628	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.007359	517,818	3,811	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	745,370	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	798,425	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	38,579	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000363	30,050	11	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,346	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	134,091	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001090	2,677,039	2,918	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	121,324	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC	0.000000	0	0	0	0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000	0	0	0	0	88.01
88.02	08802	MT STERLING RHC	0.000000	0	0	0	0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000	0	0	0	0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000	0	0	0	0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.010302	0	0	0	0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000	0	0	0	0	88.06
88.07	08807	PALMYRA RHC	0.000000	0	0	0	0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000	0	0	0	0	88.08
90.00	09000	CLINIC	0.001647	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.014984	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.003325	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.003185	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		6,727,994	9,453	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.199796	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	0	0	0	0	55.00
57.00	05700	CT SCAN	0.015733	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	0	0	0	0	58.00
60.00	06000	LABORATORY	0.084011	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.154502	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053575	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.222199	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	0	0	12,364	0	73.00
74.00	07400	RENAL DIALYSIS	0.502931	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EAST ADAMS RHC						88.00
88.01	08801	48TH AND MAINE RHC						88.01
88.02	08802	MT STERLING RHC						88.02
88.03	08803	MAIN CAMPUS RHC						88.03
88.04	08804	BLESSING EXPRESS CLINIC						88.04
88.05	08805	BLESSING WALK IN CLINIC						88.05
88.06	08806	HANNIBAL MAIN RHC						88.06
88.07	08807	PALMYRA RHC						88.07
88.08	08808	BOWLING GREEN RHC						88.08
90.00	09000	CLINIC	0.453687	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	0	0	0	0	90.01
90.02	04950	ONCOLOGY	0.375342	0	0	0	0	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.214145	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	12,364	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	12,364	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,159		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC				88.00
88.01	08801	48TH AND MAINE RHC				88.01
88.02	08802	MT STERLING RHC				88.02
88.03	08803	MAIN CAMPUS RHC				88.03
88.04	08804	BLESSING EXPRESS CLINIC				88.04
88.05	08805	BLESSING WALK IN CLINIC				88.05
88.06	08806	HANNIBAL MAIN RHC				88.06
88.07	08807	PALMYRA RHC				88.07
88.08	08808	BOWLING GREEN RHC				88.08
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
90.02	04950	ONCOLOGY	0	0		90.02
90.03	04951	HANNIBAL INFUSION	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	1,159		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,159		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	63,618	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	63,618	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	58,470	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	20,926	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	103,601,378	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	103,601,378	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	103,601,378	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,628.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	34,077,782	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	34,077,782	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,685,146	5,809	2,355.85	2,139	5,039,163	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	31,391,246	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	70,508,191	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	4,374,039	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,878,834	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,252,873	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	63,255,318	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	5,148	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,628.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	8,383,467	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,752,585	103,601,378	0.074831	8,383,467	627,343	90.00
91.00	Nursing Program cost	4,122,537	103,601,378	0.039792	8,383,467	333,595	91.00
92.00	Allied health cost	0	103,601,378	0.000000	8,383,467	0	92.00
93.00	All other Medical Education	0	103,601,378	0.000000	8,383,467	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,630	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,630	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,630	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,790	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,633,416	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,633,416	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,633,416	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,216.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,394,649	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,394,649	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,126,768	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	4,521,417	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	284,748	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	70,584	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	355,332	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,166,085	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	421,357	5,633,416	0.074796	0	0	90.00
91.00	Nursing Program cost	51,180	5,633,416	0.009085	0	0	91.00
92.00	Allied health cost	0	5,633,416	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,633,416	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,765	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,765	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,297	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,698,924	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,698,924	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,698,924	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	5,698,924	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,196.00	71.00
72.00	Program routine service cost (line 9 x line 71)	3,943,212	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	3,943,212	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	3,943,212	83.00
84.00	Program inpatient ancillary services (see instructions)	1,065,687	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	5,008,899	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		58,647,995		30.00
31.00	03100	INTENSIVE CARE UNIT		23,973,709		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199885	24,881,630	4,973,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	8,045,492	190,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	9,617,041	1,530,264	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	471,510	69,064	55.00
57.00	05700	CT SCAN	0.015733	24,599,417	387,023	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	4,807,449	228,325	58.00
60.00	06000	LABORATORY	0.084011	43,225,411	3,631,410	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	2,655,676	459,838	62.00
65.00	06500	RESPIRATORY THERAPY	0.154679	10,082,957	1,559,622	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	1,463,852	530,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	1,018,878	267,011	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	509,358	100,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053701	22,538,530	1,210,342	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.223076	417,125	93,051	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	30,804,380	3,797,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	25,733,011	3,923,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	59,436,071	5,572,726	73.00
74.00	07400	RENAL DIALYSIS	0.502931	1,073,942	540,119	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC	0.000000		0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000		0	88.01
88.02	08802	MT STERLING RHC	0.000000		0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000		0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000		0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.000000		0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000		0	88.06
88.07	08807	PALMYRA RHC	0.000000		0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000		0	88.08
90.00	09000	CLINIC	0.453698	29,301	13,294	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	10,579	3,340	90.01
90.02	04950	ONCOLOGY	0.375342	9,853	3,698	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	0	0	90.03
91.00	09100	EMERGENCY	0.215638	8,580,782	1,850,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	958,408	454,617	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		280,970,653	31,391,246	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		280,970,653		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		5,508,340		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199885	51,557	10,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	2,662	63	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	185,665	29,543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	0	0	55.00
57.00	05700	CT SCAN	0.015733	98,098	1,543	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	43,949	2,087	58.00
60.00	06000	LABORATORY	0.084011	808,471	67,920	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	27,999	4,848	62.00
65.00	06500	RESPIRATORY THERAPY	0.154679	195,180	30,190	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	1,230,811	445,946	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	1,233,256	323,192	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	273,368	54,042	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053701	15,875	853	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.223076	4,009	894	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	82,527	10,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	10,523	1,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	1,456,074	136,521	73.00
74.00	07400	RENAL DIALYSIS	0.502931	13,999	7,041	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC	0.000000		0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000		0	88.01
88.02	08802	MT STERLING RHC	0.000000		0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000		0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000		0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.000000		0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000		0	88.06
88.07	08807	PALMYRA RHC	0.000000		0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000		0	88.08
90.00	09000	CLINIC	0.453698	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	0	0	90.01
90.02	04950	ONCOLOGY	0.375342	0	0	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	0	0	90.03
91.00	09100	EMERGENCY	0.215638	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,734,023	1,126,768	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,734,023		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.199885	78,390	15,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023739	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159120	196,955	31,339	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.146475	0	0	55.00
57.00	05700	CT SCAN	0.015733	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047494	0	0	58.00
60.00	06000	LABORATORY	0.084011	1,339,979	112,573	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.173153	44,628	7,727	62.00
65.00	06500	RESPIRATORY THERAPY	0.154679	517,818	80,096	65.00
66.00	06600	PHYSICAL THERAPY	0.362319	745,370	270,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262064	798,425	209,238	67.00
68.00	06800	SPEECH PATHOLOGY	0.197688	38,579	7,627	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053701	30,050	1,614	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.223076	5,346	1,193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123287	134,091	16,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152483	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.093760	2,677,039	250,999	73.00
74.00	07400	RENAL DIALYSIS	0.502931	121,324	61,018	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EAST ADAMS RHC	0.000000		0	88.00
88.01	08801	48TH AND MAINE RHC	0.000000		0	88.01
88.02	08802	MT STERLING RHC	0.000000		0	88.02
88.03	08803	MAIN CAMPUS RHC	0.000000		0	88.03
88.04	08804	BLESSING EXPRESS CLINIC	0.000000		0	88.04
88.05	08805	BLESSING WALK IN CLINIC	0.000000		0	88.05
88.06	08806	HANNIBAL MAIN RHC	0.000000		0	88.06
88.07	08807	PALMYRA RHC	0.000000		0	88.07
88.08	08808	BOWLING GREEN RHC	0.000000		0	88.08
90.00	09000	CLINIC	0.453698	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.315745	0	0	90.01
90.02	04950	ONCOLOGY	0.375342	0	0	90.02
90.03	04951	HANNIBAL INFUSION	2.098429	0	0	90.03
91.00	09100	EMERGENCY	0.215638	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.474346	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.615592	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,727,994	1,065,687	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,727,994		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	48,149,548	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	1,931,823	2.04
3.00	Managed Care Simulated Payments	32,318,488	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	294.90	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	13.16	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	18.25	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	13.16	12.00
13.00	Total allowable FTE count for the prior year.	13.16	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	13.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.	13.16	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	13.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.044625	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.044517	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.044517	21.00
22.00	IME payment adjustment (see instructions)	1,156,793	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	776,452	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	5.09	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	1,156,793	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	776,452	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.83	31.00
32.00	Sum of lines 30 and 31	29.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.92	33.00
34.00	Disproportionate share adjustment (see instructions)	1,675,604	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000404389	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	0	2,152,778	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	0	2,152,778	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	2,152,778		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	55,066,546		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	57,670,154		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		58,446,606	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,901,829	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		711,733	52.00
53.00	Nursing and Allied Health Managed Care payment		399,680	53.00
54.00	Special add-on payments for new technologies		258,570	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		1,463,212	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		335,195	58.00
59.00	Total (sum of amounts on lines 49 through 58)		65,516,825	59.00
60.00	Primary payer payments		3,400	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		65,513,425	61.00
62.00	Deductibles billed to program beneficiaries		5,336,608	62.00
63.00	Coinsurance billed to program beneficiaries		99,692	63.00
64.00	Allowable bad debts (see instructions)		646,973	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		420,532	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		645,489	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		60,497,657	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-111,338	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		60,386,319	71.00
71.01	Sequestration adjustment (see instructions)		1,207,726	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		60,669,960	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,491,367	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,727,117	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,746	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	36,636,207	2.00
3.00	OPPS or REH payments	34,737,438	3.00
4.00	Outlier payment (see instructions)	275,544	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	367,221	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,746	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	103,951	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	103,951	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	103,951	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	94,205	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,746	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	35,380,203	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	201,319	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,586,563	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	29,602,067	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	339,453	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	29,941,520	30.00
31.00	Primary payer payments	2,514	31.00
32.00	Subtotal (line 30 minus line 31)	29,939,006	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	152,442	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	99,087	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	152,394	36.00
37.00	Subtotal (see instructions)	30,038,093	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-98	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	30,038,191	40.00
40.01	Sequestration adjustment (see instructions)	600,764	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	29,615,180	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-177,753	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	43	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	43	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	462	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	462	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	462	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	419	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	43	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	43	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	43	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	43	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	43	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	43	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	215	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-173	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,159	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,159	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	12,364	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	12,364	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	12,364	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	11,205	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,159	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,159	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,159	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,159	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,159	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,159	40.00
40.01	Sequestration adjustment (see instructions)	23	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	12,364	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-11,228	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		61,912,962		29,753,195	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	01/31/2023	37,973	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	01/31/2023	337,359	05/31/2023	175,988	3.50
3.51		05/31/2023	905,643		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,243,002		-138,015	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		60,669,960		29,615,180	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,491,367		177,753	6.02
7.00	Total Medicare program liability (see instructions)		59,178,593		29,437,427	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,225,813		215	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/31/2023	86,978		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		86,978		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,312,791		215	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		10,626		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		173	6.02
7.00	Total Medicare program liability (see instructions)		8,323,417		42	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,891,925		12,364	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,891,925		12,364	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		27,488		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		11,228	6.02
7.00	Total Medicare program liability (see instructions)		1,919,413		1,136	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part III Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,128,932	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0469	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	312,964	3.00
4.00	Outlier Payments	68,592	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	12.684932	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	8,510,488	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	8,510,488	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8,510,488	19.00
20.00	Deductibles	20,580	20.00
21.00	Subtotal (line 19 minus line 20)	8,489,908	21.00
22.00	Coinsurance	42,778	22.00
23.00	Subtotal (line 21 minus line 22)	8,447,130	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,654	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	10,175	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,654	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,457,305	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	35,978	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,493,283	32.00
32.01	Sequestration adjustment (see instructions)	169,866	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,312,791	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	10,626	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	48,774	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	68,592	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2,041,621	1.00
2.00	Routine service other pass through costs	18,035	2.00
3.00	Ancillary service other pass through costs	9,453	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,069,109	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	111,085	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,958,024	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,958,024	15.00
15.01	Sequestration adjustment (see instructions)	38,611	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	1,891,925	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	27,488	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			18.25	6.00
7.00	Enter the lesser of line 5 or line 6			18.25	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	18.25	0.00	18.25	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	18.25	0.00	18.25	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	18.25	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.95	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.07	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.76	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	17.76	0.00		17.00
18.00	Per resident amount	103,488.99	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	1,837,964	0	1,837,964	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,837,964	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	25,855	3,376	11,004		26.00
27.00	Total Inpatient Days (see instructions)	69,530	69,530	69,530		27.00
28.00	Ratio of inpatient days to total inpatient days	0.371854	0.048555	0.158263		28.00
29.00	Program direct GME amount	683,454	89,242	290,882	1,063,578	29.00
29.01	Percent reduction for MA DGME		3.26	3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,909	9,483	12,392	30.00
31.00	Net Program direct GME amount				1,051,186	31.00

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	2,440,193	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	81,041,929	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	3,400	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	81,038,529	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	38,653,609	42.00
43.00	Primary payer payments (see instructions)	3,200	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	38,650,409	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	119,688,938	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.677076	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.322924	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	1,051,186	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	711,733	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	339,453	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 12/29/2023 3:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	72,308,306	0	0	0	1.00
2.00	Temporary investments	160,622,404	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	461,997,429	0	0	0	4.00
5.00	Other receivable	24,339,814	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-358,892,594	0	0	0	6.00
7.00	Inventory	12,080,841	0	0	0	7.00
8.00	Prepaid expenses	8,313,278	0	0	0	8.00
9.00	Other current assets	254,914	0	0	0	9.00
10.00	Due from other funds	1,025,976	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	382,050,368	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	16,905,128	0	0	0	12.00
13.00	Land improvements	13,522,538	0	0	0	13.00
14.00	Accumulated depreciation	-6,973,169	0	0	0	14.00
15.00	Buildings	350,341,319	0	0	0	15.00
16.00	Accumulated depreciation	-120,161,634	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	253,242,146	0	0	0	23.00
24.00	Accumulated depreciation	-166,317,945	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	340,558,383	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,102,263	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	16,208,163	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,310,426	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	761,919,177	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	27,839,883	0	0	0	37.00
38.00	Salaries, wages, and fees payable	33,460,539	0	0	0	38.00
39.00	Payroll taxes payable	1,534,491	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,146,236	0	0	0	40.00
41.00	Deferred income	1,795,978	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	29,155,555	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	98,932,682	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	129,866,390	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,765,196	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	169,631,586	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	268,564,268	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	493,354,909				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	493,354,909	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	761,919,177	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 12/29/2023 3:54 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		452,758,567		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		25,728,233				2.00
3.00	Total (sum of line 1 and line 2)		478,486,800		0		3.00
4.00	TRANSFER OF CLINIC ASSETS	17,179,328		0		0	4.00
5.00	OTHER	501		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		17,179,829		0		10.00
11.00	Subtotal (line 3 plus line 10)		495,666,629		0		11.00
12.00	RELEASED FROM RESTRICTIONS	1,559,768		0		0	12.00
13.00	ADOPTION OF ASC 842	751,952		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,311,720		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		493,354,909		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	TRANSFER OF CLINIC ASSETS		0		4.00
5.00	OTHER		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	RELEASED FROM RESTRICTIONS		0		12.00
13.00	ADOPTION OF ASC 842		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 12/29/2023 3:54 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	176,982,503		176,982,503	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	9,395,964		9,395,964	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	7,519,805		7,519,805	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)	193,898,272		193,898,272	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	65,754,380		65,754,380	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	65,754,380		65,754,380	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	259,652,652		259,652,652	17.00
18.00	Ancillary services	775,234,123	1,250,266,919	2,025,501,042	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	EAST ADAMS RHC	0	1,098,603	1,098,603	20.00
20.01	48TH AND MAINE RHC	0	2,550,377	2,550,377	20.01
20.02	MT STERLING RHC	0	390,917	390,917	20.02
20.03	MAIN CAMPUS RHC	0	27,734,135	27,734,135	20.03
20.04	BLESSING EXPRESS CLINIC	0	2,473,655	2,473,655	20.04
20.05	BLESSING WALK IN CLINIC	0	4,587,347	4,587,347	20.05
20.06	HANNIBAL MAIN RHC	0	5,680,371	5,680,371	20.06
20.07	PALMYRA RHC	0	403,369	403,369	20.07
20.08	BOWLING GREEN RHC	0	134,164	134,164	20.08
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		6,553,346	6,553,346	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	423,506	6,192,940	6,616,446	26.00
27.00	NURSERY	4,592,006	0	4,592,006	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,039,902,287	1,308,066,143	2,347,968,430	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		616,826,317		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		616,826,317		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 12/29/2023 3:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,347,968,430	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,785,949,030	2.00
3.00	Net patient revenues (line 1 minus line 2)	562,019,400	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	616,826,317	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-54,806,917	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	16,103,546	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	2,067,173	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	121,089	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,608,507	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	2,368,645	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	24,621,920	24.00
24.01	TRANSFERS	7,098,582	24.01
24.02	RETAIL PHARMACIES	21,769,289	24.02
24.50	COVID-19 PHE Funding	1,776,399	24.50
25.00	Total other income (sum of lines 6-24)	80,535,150	25.00
26.00	Total (line 5 plus line 25)	25,728,233	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,728,233	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015 HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H Date/Time Prepared: 12/29/2023 3:54 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	571,641	0	0	0	0	571,641	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,009,961	0	132,062	0	247,311	1,389,334	6.00
7.00	Physical Therapy	854,021	0	86,295	0	161,604	1,101,920	7.00
8.00	Occupational Therapy	271,021	0	30,530	0	57,173	358,724	8.00
9.00	Speech Pathology	66,404	0	4,481	0	8,392	79,277	9.00
10.00	Medical Social Services	97,775	0	588	0	1,101	99,464	10.00
11.00	Home Health Aide	217,232	0	26,132	0	48,938	292,302	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,088,055	0	280,088	0	524,519	3,892,662	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	571,641	0	571,641			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-14,310	1,375,024	-8,058	1,366,966			6.00
7.00	Physical Therapy	0	1,101,920	0	1,101,920			7.00
8.00	Occupational Therapy	0	358,724	0	358,724			8.00
9.00	Speech Pathology	0	79,277	0	79,277			9.00
10.00	Medical Social Services	0	99,464	0	99,464			10.00
11.00	Home Health Aide	0	292,302	0	292,302			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-14,310	3,878,352	-8,058	3,870,294			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-1 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	571,641	0	0	0	0	571,641	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,366,966	0	0	0	0	1,366,966	6.00
7.00	Physical Therapy	1,101,920	0	0	0	0	1,101,920	7.00
8.00	Occupational Therapy	358,724	0	0	0	0	358,724	8.00
9.00	Speech Pathology	79,277	0	0	0	0	79,277	9.00
10.00	Medical Social Services	99,464	0	0	0	0	99,464	10.00
11.00	Home Health Aide	292,302	0	0	0	0	292,302	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,870,294	0	0	0	0	3,870,294	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	571,641			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	236,890	1,603,856		6.00
7.00	Physical Therapy	190,957	1,292,877		7.00
8.00	Occupational Therapy	62,165	420,889		8.00
9.00	Speech Pathology	13,738	93,015		9.00
10.00	Medical Social Services	17,237	116,701		10.00
11.00	Home Health Aide	50,654	342,956		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		3,870,294		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-1 Part II | Date/Time Prepared: 12/29/2023 3:54 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-571,641	3,298,653	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,366,966	6.00
7.00	Physical Therapy	0	0	0	0	0	1,101,920	7.00
8.00	Occupational Therapy	0	0	0	0	0	358,724	8.00
9.00	Speech Pathology	0	0	0	0	0	79,277	9.00
10.00	Medical Social Services	0	0	0	0	0	99,464	10.00
11.00	Home Health Aide	0	0	0	0	0	292,302	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-571,641	3,298,653	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		571,641	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.173295	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	MOB	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	1,603,856	0	0	0	0	0	2.00
3.00	Physical Therapy	1,292,877	0	0	0	0	0	3.00
4.00	Occupational Therapy	420,889	0	0	0	0	0	4.00
5.00	Speech Pathology	93,015	0	0	0	0	0	5.00
6.00	Medical Social Services	116,701	0	0	0	0	0	6.00
7.00	Home Health Aide	342,956	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,870,294	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAPITAL RELATED COSTS OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	HANNIBAL	MVBLE EQUIP	
		1.05	1.06	1.07	1.08	1.09	2.00	
1.00	Administrative and General	22,285	0	0	0	0	466	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	22,285	0	0	0	0	466	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Home Health Agency I | PPS

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	4A	5.00	6.00	8.00	9.00	
1.00	Administrative and General	177,983	200,734	56,381	47,706	0	27,745	1.00
2.00	Skilled Nursing Care	0	1,603,856	450,481	0	0	0	2.00
3.00	Physical Therapy	0	1,292,877	363,134	0	0	0	3.00
4.00	Occupational Therapy	0	420,889	118,216	0	0	0	4.00
5.00	Speech Pathology	0	93,015	26,125	0	0	0	5.00
6.00	Medical Social Services	0	116,701	32,778	0	0	0	6.00
7.00	Home Health Aide	0	342,956	96,327	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	177,983	4,071,028	1,143,442	47,706	0	27,745	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
		10.00	11.00	13.00	16.00	20.00	21.00	
1.00	Administrative and General	0	0	868,017	0	55,330	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	868,017	0	55,330	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

Home Health Agency I | PPS

	Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	
		22.00	23.00	23.01	23.02	23.03	23.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	1,255,913	0	1,255,913				1.00
2.00	Skilled Nursing Care	2,054,337	0	2,054,337	520,455	2,574,792		2.00
3.00	Physical Therapy	1,656,011	0	1,656,011	419,539	2,075,550		3.00
4.00	Occupational Therapy	539,105	0	539,105	136,578	675,683		4.00
5.00	Speech Pathology	119,140	0	119,140	30,183	149,323		5.00
6.00	Medical Social Services	149,479	0	149,479	37,869	187,348		6.00
7.00	Home Health Aide	439,283	0	439,283	111,289	550,572		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	6,213,268	0	6,213,268	1,255,913	6,213,268		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.253343			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 HHA CCN: 14-7031

Period: From 10/01/2022 To 09/30/2023

Worksheet H-2 Part II Date/Time Prepared: 12/29/2023 3:54 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB (SQUARE FEET)	OAK STREET MALL (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	0	2,046	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,046	20.00
21.00	Total cost to be allocated	0	0	0	0	0	22,285	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	10.891984	22.00

	Cost Center Description	CAPITAL RELATED COSTS BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	48TH AND MAINE (SQUARE FEET)	HANNIBAL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.06	1.07	1.08	1.09	2.00	4.00	
1.00	Administrative and General	0	0	0	0	470	3,079,669	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	470	3,079,669	20.00
21.00	Total cost to be allocated	0	0	0	0	466	177,983	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.991489	0.057793	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 HHA CCN: 14-7031

Period: From 10/01/2022 To 09/30/2023

Worksheet H-2 Part II Date/Time Prepared: 12/29/2023 3:54 pm

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	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5A	5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	0	200,734	2,046	0	355	0	1.00
2.00	Skilled Nursing Care	0	1,603,856	0	0	0	0	2.00
3.00	Physical Therapy	0	1,292,877	0	0	0	0	3.00
4.00	Occupational Therapy	0	420,889	0	0	0	0	4.00
5.00	Speech Pathology	0	93,015	0	0	0	0	5.00
6.00	Medical Social Services	0	116,701	0	0	0	0	6.00
7.00	Home Health Aide	0	342,956	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)		4,071,028	2,046	0	355	0	20.00
21.00	Total cost to be allocated		1,143,442	47,706	0	27,745	0	21.00
22.00	Unit cost multiplier		0.280873	23.316716	0.000000	78.154930	0.000000	22.00

	Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		11.00	13.00	16.00	20.00	21.00	22.00	
1.00	Administrative and General	0	83,755	0	240	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	83,755	0	240	0	0	20.00
21.00	Total cost to be allocated	0	868,017	0	55,330	0	0	21.00
22.00	Unit cost multiplier	0.000000	10.363763	0.000000	230.541667	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015
HHA CCN: 14-7031

Period:
From 10/01/2022
To 09/30/2023

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)		
		23.00	23.01	23.02	23.03	23.04		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 12/29/2023 3:54 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	2,574,792		2,574,792	16,720	153.99	1.00
2.00	Physical Therapy	3.00	2,075,550	0	2,075,550	10,924	190.00	2.00
3.00	Occupational Therapy	4.00	675,683	0	675,683	3,865	174.82	3.00
4.00	Speech Pathology	5.00	149,323	0	149,323	566	263.82	4.00
5.00	Medical Social Services	6.00	187,348		187,348	74	2,531.73	5.00
6.00	Home Health Aide	7.00	550,572		550,572	3,308	166.44	6.00
7.00	Total (sum of lines 1-6)		6,213,268	0	6,213,268	35,457		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	4,872			8.00
8.01	Skilled Nursing Care		99926	0	1,168			8.01
9.00	Physical Therapy		99914	0	4,086			9.00
9.01	Physical Therapy		99926	0	1,315			9.01
10.00	Occupational Therapy		99914	0	1,463			10.00
10.01	Occupational Therapy		99926	0	330			10.01
11.00	Speech Pathology		99914	0	163			11.00
11.01	Speech Pathology		99926	0	27			11.01
12.00	Medical Social Services		99914	0	35			12.00
12.01	Medical Social Services		99926	0	5			12.01
13.00	Home Health Aide		99914	0	1,453			13.00
13.01	Home Health Aide		99926	0	276			13.01
14.00	Total (sum of lines 8-13)			0	15,193			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	10,120	10,120	82,082	0.123291	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	6,040		0	930,100		1.00
2.00	Physical Therapy	0	5,401		0	1,026,190		2.00
3.00	Occupational Therapy	0	1,793		0	313,452		3.00
4.00	Speech Pathology	0	190		0	50,126		4.00
5.00	Medical Social Services	0	40		0	101,269		5.00
6.00	Home Health Aide	0	1,729		0	287,775		6.00
7.00	Total (sum of lines 1-6)	0	15,193		0	2,708,912		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0015 HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 12/29/2023 3:54 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	82,082	0	0	10,120	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	930,100						1.00
2.00	Physical Therapy	1,026,190						2.00
3.00	Occupational Therapy	313,452						3.00
4.00	Speech Pathology	50,126						4.00
5.00	Medical Social Services	101,269						5.00
6.00	Home Health Aide	287,775						6.00
7.00	Total (sum of lines 1-6)	2,708,912						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015
HHA CCN: 14-7031

Period:
From 10/01/2022
To 09/30/2023

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.362319	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.262064	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.197688	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.123287	82,082	10,120	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.093760	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 12/29/2023 3:54 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	2,533,318	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	2,533,318	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	2,533,318	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	2,559,896	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	99,207	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	31,353	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	42,480	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	28,826	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	141	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	2,761,903	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	2,761,903	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	2,761,903	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	2,761,903	29.00
30.00	MSP AND PRIOR AUTHORIZATION AMOUNT	0	-1,183	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	2,760,720	31.00
31.01	Sequestration adjustment (see instructions)	0	55,215	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	2,705,505	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2022 To 09/30/2023 | Worksheet H-5 | Date/Time Prepared: 12/29/2023 3:54 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,705,505	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,705,505	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,705,505	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	402,307	80,419	482,726	0	482,726	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	161,287	161,287	0	161,287	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	144,366	2,410	146,776	0	146,776	26.00
27.00	NURSE PRACTITIONER**	37,683	2,373	40,056	0	40,056	27.00
28.00	REGISTERED NURSE**	754,752	0	754,752	-8,403	746,349	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	90,230	0	90,230	0	90,230	33.00
34.00	SPIRITUAL COUNSELING**	89,426	0	89,426	0	89,426	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	113,749	0	113,749	0	113,749	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219,308	219,308	0	219,308	38.00
39.00	PATIENT TRANSPORTATION**	0	6,550	6,550	0	6,550	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	1,200	1,200	0	1,200	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	58,407	58,407	-4,484	53,923	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	173,189	173,189	0	173,189	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	19,095	0	19,095	0	19,095	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	26,957	26,957	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	529,940	10,814	540,754	0	540,754	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	2,181,548	715,957	2,897,505	14,070	2,911,575	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	-1,676	481,050		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	161,287		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	175,300	175,300		25.00
26.00	PHYSICIAN SERVICES**	0	146,776		26.00
27.00	NURSE PRACTITIONER**	0	40,056		27.00
28.00	REGISTERED NURSE**	0	746,349		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	90,230		33.00
34.00	SPIRITUAL COUNSELING**	0	89,426		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	113,749		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219,308		38.00
39.00	PATIENT TRANSPORTATION**	0	6,550		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	1,200		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	53,923		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	173,189		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	19,095		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	26,957		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	540,754		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	173,624	3,085,199		100.00

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

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

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O-2 | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	144,366	2,410	146,776	0	146,776	26.00
27.00	NURSE PRACTITIONER	37,683	2,373	40,056	0	40,056	27.00
28.00	REGISTERED NURSE	711,183	0	711,183	-8,403	702,780	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	87,465	0	87,465	0	87,465	33.00
34.00	SPIRITUAL COUNSELING	86,770	0	86,770	0	86,770	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	113,364	0	113,364	0	113,364	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	219,308	219,308	0	219,308	38.00
39.00	PATIENT TRANSPORTATION	0	6,550	6,550	0	6,550	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	1,200	1,200	0	1,200	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	58,363	58,363	-4,484	53,879	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	173,060	173,060	0	173,060	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	19,095	0	19,095	0	19,095	46.00
100.00	TOTAL *	1,199,926	463,264	1,663,190	-12,887	1,650,303	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	146,776		26.00
27.00	NURSE PRACTITIONER	0	40,056		27.00
28.00	REGISTERED NURSE	0	702,780		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	87,465		33.00
34.00	SPIRITUAL COUNSELING	0	86,770		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	113,364		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	219,308		38.00
39.00	PATIENT TRANSPORTATION	0	6,550		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	1,200		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	53,879		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	173,060		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	19,095		46.00
100.00	TOTAL *	0	1,650,303		100.00

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

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

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O-3 | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,215	0	1,215	0	1,215	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	161	0	161	0	161	33.00
34.00	SPIRITUAL COUNSELING	72	0	72	0	72	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	385	0	385	0	385	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	44	44	0	44	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	129	129	0	129	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,833	173	2,006	0	2,006	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	2,294	2,294		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,215		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	161		33.00
34.00	SPIRITUAL COUNSELING	0	72		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	385		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	44		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	129		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	2,294	4,300		100.00

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

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

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	42,354	0	42,354	0	42,354	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	2,604	0	2,604	0	2,604	33.00
34.00	SPIRITUAL COUNSELING	2,584	0	2,584	0	2,584	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	47,542	0	47,542	0	47,542	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	173,006	173,006		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	42,354		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	2,604		33.00
34.00	SPIRITUAL COUNSELING	0	2,584		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	173,006	220,548		100.00

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

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

Provider CCN: 14-0015 Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O-5 | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,880	7,880	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	126,927	126,927	3.00
4.00	ADMINISTRATIVE & GENERAL	481,050	904,413	1,385,463	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	521,940	521,940	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	161,287		161,287	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	5,764	5,764	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,650,303		1,650,303	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4,300		4,300	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	220,548		220,548	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	26,957		26,957	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	540,754		540,754	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	3,085,199	1,566,924	4,652,123	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

Worksheet O-6 Part I
Date/Time Prepared: 12/29/2023 3:54 pm

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
					Hospice I		
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,880		7,880			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	126,927	0	0	126,927		3.00
4.00	ADMINISTRATIVE & GENERAL	1,385,463	0	7,880	23,251	1,416,594	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	521,940	0	0	0	521,940	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	161,287	0	0	0	161,287	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	1,334	1,334	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	5,764	0	0	0	5,764	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,650,303			68,861	1,719,164	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4,300	0	0	106	4,406	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	220,548	0	0	2,748	223,296	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	26,957	0	0	0	26,957	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	540,754	0	0	30,627	571,381	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	4,652,123	0	7,880	126,927	4,652,123	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

Worksheet O-6 Part I
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	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,416,594					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	228,518	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	70,615	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	584	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	2,524	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	752,692					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,929	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	97,765	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	11,802	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	250,165	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,416,594	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

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	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	750,458					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			231,902		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	1,918	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	750,458	0	0	225,033	1,862	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	168	1	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	6,701	55	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	750,458	0	0	231,902	1,918	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		8,288			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	8,288		3,457,497	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	6,504	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	327,817	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		38,759	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		821,546	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	8,288	0	4,652,123	100.00

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

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2022
To 09/30/2023

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	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		7,956				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,196,230			3.00
4.00	ADMINISTRATIVE & GENERAL	0	7,956	402,307	-1,416,594	3,235,529	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	521,940	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	161,287	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	23,085	0	1,334	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	5,764	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,191,523	0	1,719,164	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1,833	0	4,406	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	47,542	0	223,296	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	26,957	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	529,940	0	571,381	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	7,880	126,927		1,416,594	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.990447	0.057793		0.437825	101.00

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

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
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	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		50,362	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					50,362	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	0	750,458	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	14.901275	101.00

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

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			20,661			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	20,661		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	20,049	20,049	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	15	15	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	597	597	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	231,902	1,918	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	11.224142	0.092832	0.000000	101.00

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

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

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	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		25			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	25			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	8,288	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	331.520000	0.000000		101.00

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

Provider CCN: 14-0015 Hospice CCN: 14-1501

Period: From 10/01/2022 To 09/30/2023

Worksheet O-7

Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.362319	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.262064	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.197688	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.093760	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.084011	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.123287	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	93.99	0.615592	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.146475	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2022 To 09/30/2023 | Worksheet O-8 | Date/Time Prepared: 12/29/2023 3:54 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			3,457,497	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			20,049	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			172.45	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	18,500	733		9.00
10.00	Program cost (line 8 times line 9)	3,190,325	126,406		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			6,504	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			15	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			433.60	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	15	0		14.00
15.00	Program cost (line 13 times line 14)	6,504	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			327,817	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			597	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			549.11	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	520	40		19.00
20.00	Program cost (line 18 times line 19)	285,537	21,964		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,791,818	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			20,661	22.00
23.00	Average cost per diem (line 21 divided by line 22)			183.53	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0015	Period: From 10/01/2022 To 09/30/2023	Worksheet L Parts I-III Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		3,603,518	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		223,358	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		180.39	3.00
4.00	Number of interns & residents (see instructions)		13.16	4.00
5.00	Indirect medical education percentage (see instructions)		2.08	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		74,953	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		3,901,829	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	228,557	0	228,557	0	228,557	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	212,144	31,230	243,374	0	243,374	9.00
10.00	Subtotal (sum of lines 1 through 9)	440,701	31,230	471,931	0	471,931	10.00
11.00	Physician Services Under Agreement	0	144,305	144,305	0	144,305	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	144,305	144,305	0	144,305	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	440,701	175,535	616,236	0	616,236	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	2,313	1,012	3,325	0	3,325	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	2,313	1,012	3,325	0	3,325	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	98,605	98,605	49,250	147,855	29.00
30.00	Administrative Costs	118,053	29,133	147,186	0	147,186	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	118,053	127,738	245,791	49,250	295,041	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	561,067	304,285	865,352	49,250	914,602	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-3422 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	228,557		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	243,374		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	471,931		10.00
11.00	Physician Services Under Agreement	0	144,305		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	144,305		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	616,236		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	3,325		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,325		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-86,302	61,553		29.00
30.00	Administrative Costs	4,629	151,815		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-81,673	213,368		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-81,673	832,929		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	973,260	0	973,260	0	973,260	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	68,788	0	68,788	0	68,788	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	459,021	112,683	571,704	0	571,704	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,501,069	112,683	1,613,752	0	1,613,752	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,501,069	112,683	1,613,752	0	1,613,752	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	66	9	75	0	75	25.01
25.02	Chronic Care Management	66	9	75	0	75	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	132	18	150	0	150	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	332,341	1,152	333,493	0	333,493	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	332,341	1,152	333,493	0	333,493	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,833,542	113,853	1,947,395	0	1,947,395	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	973,260		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	68,788		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	571,704		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,613,752		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,613,752		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	75		25.01
25.02	Chronic Care Management	0	75		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	150		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	10,126	343,619		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	10,126	343,619		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	10,126	1,957,521		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8630 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	104,768	0	104,768	0	104,768	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	171,612	25,808	197,420	-70,941	126,479	9.00
10.00	Subtotal (sum of lines 1 through 9)	276,380	25,808	302,188	-70,941	231,247	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	276,380	25,808	302,188	-70,941	231,247	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	730	316	1,046	0	1,046	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	730	316	1,046	0	1,046	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	99,526	99,526	69,681	169,207	29.00
30.00	Administrative Costs	151,440	28,627	180,067	0	180,067	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	151,440	128,153	279,593	69,681	349,274	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	428,550	154,277	582,827	-1,260	581,567	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8630 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	104,768		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	126,479		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	231,247		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	231,247		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	1,046		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,046		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-65,127	104,080		29.00
30.00	Administrative Costs	1,663	181,730		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-63,464	285,810		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-63,464	518,103		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	8,221,330	367,940	8,589,270	0	8,589,270	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,438,850	0	1,438,850	0	1,438,850	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	3,977,928	1,116,804	5,094,732	-191,875	4,902,857	9.00
10.00	Subtotal (sum of lines 1 through 9)	13,638,108	1,484,744	15,122,852	-191,875	14,930,977	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	13,638,108	1,484,744	15,122,852	-191,875	14,930,977	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	973,384	162,669	1,136,053	-70,420	1,065,633	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	973,384	162,669	1,136,053	-70,420	1,065,633	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	877,748	877,748	-877,748	0	29.00
30.00	Administrative Costs	1,131,560	33,026	1,164,586	0	1,164,586	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,131,560	910,774	2,042,334	-877,748	1,164,586	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	15,743,052	2,558,187	18,301,239	-1,140,043	17,161,196	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-3,251,014	5,338,256		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-260,704	1,178,146		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-398,086	4,504,771		9.00
10.00	Subtotal (sum of lines 1 through 9)	-3,909,804	11,021,173		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,909,804	11,021,173		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	1,065,633		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,065,633		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	83,278	1,247,864		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	83,278	1,247,864		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,826,526	13,334,670		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8634 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	521,180	0	521,180	0	521,180	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	484,749	24,762	509,511	0	509,511	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,005,929	24,762	1,030,691	0	1,030,691	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,005,929	24,762	1,030,691	0	1,030,691	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	95,069	95,069	29.00
30.00	Administrative Costs	187,874	176,640	364,514	24,200	388,714	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	187,874	176,640	364,514	119,269	483,783	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,193,803	201,402	1,395,205	119,269	1,514,474	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8634 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	521,180		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	509,511		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,030,691		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,030,691		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	95,069		29.00
30.00	Administrative Costs	12,699	401,413		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	12,699	496,482		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	12,699	1,527,173		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-8635 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,108,937	0	1,108,937	0	1,108,937	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	802,778	0	802,778	0	802,778	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	775,356	131,809	907,165	-1,917	905,248	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,687,071	131,809	2,818,880	-1,917	2,816,963	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,687,071	131,809	2,818,880	-1,917	2,816,963	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	54,743	60,326	115,069	0	115,069	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	54,743	60,326	115,069	0	115,069	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,741,814	192,135	2,933,949	-1,917	2,932,032	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8635 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,108,937		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	802,778		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	905,248		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,816,963		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,816,963		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	20,194	135,263		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	20,194	135,263		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	20,194	2,952,226		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VII | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,170,683	0	2,170,683	-255,114	1,915,569	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	414,105	0	414,105	-93,618	320,487	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	698,032	313,960	1,011,992	-163,265	848,727	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,282,820	313,960	3,596,780	-511,997	3,084,783	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,282,820	313,960	3,596,780	-511,997	3,084,783	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	5,497	498	5,995	0	5,995	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,497	498	5,995	0	5,995	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24,516	24,516	0	24,516	29.00
30.00	Administrative Costs	96,824	8,980	105,804	18,366	124,170	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,824	33,496	130,320	18,366	148,686	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,385,141	347,954	3,733,095	-493,631	3,239,464	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,915,569		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	320,487		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	848,727		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,084,783		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,084,783		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	5,995		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	5,995		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	24,516		29.00
30.00	Administrative Costs	0	124,170		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	148,686		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,239,464		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015
Component CCN: 26-8801
Period: From 10/01/2022 To 09/30/2023
Worksheet M-1
Date/Time Prepared: 12/29/2023 3:54 pm

RHC VIII | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	141,337	0	141,337	0	141,337	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	38,188	0	38,188	0	38,188	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	77,637	37,566	115,203	-21,475	93,728	9.00
10.00	Subtotal (sum of lines 1 through 9)	257,162	37,566	294,728	-21,475	273,253	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	257,162	37,566	294,728	-21,475	273,253	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,420	15,420	48,477	63,897	29.00
30.00	Administrative Costs	27,220	8,963	36,183	0	36,183	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,220	24,383	51,603	48,477	100,080	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	284,382	61,949	346,331	27,002	373,333	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 26-8801 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VIII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	141,337		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	38,188		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	93,728		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	273,253		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	273,253		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-5,966	57,931		29.00
30.00	Administrative Costs	518	36,701		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,448	94,632		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,448	367,885		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 26-8802 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IX | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	62,884	0	62,884	0	62,884	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	20,000	0	20,000	0	20,000	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	23,081	6,997	30,078	-10,132	19,946	9.00
10.00	Subtotal (sum of lines 1 through 9)	105,965	6,997	112,962	-10,132	102,830	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	105,965	6,997	112,962	-10,132	102,830	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,895	15,895	1,255	17,150	29.00
30.00	Administrative Costs	10,582	7,461	18,043	0	18,043	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	10,582	23,356	33,938	1,255	35,193	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	116,547	30,353	146,900	-8,877	138,023	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 26-8802 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IX | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	62,884		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	20,000		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	19,946		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	102,830		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	102,830		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	17,150		29.00
30.00	Administrative Costs	-316	17,727		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-316	34,877		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-316	137,707		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.34	1,146	4,200	1,428		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.63	4,214	2,100	3,423		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.97	5,360		4,851	5,360	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.11	153			153	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.08	5,513			5,513	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					616,236	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,325	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					619,561	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994633	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					213,368	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					275,658	15.00
16.00	Total overhead (sum of lines 14 and 15)					489,026	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					489,026	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					486,401	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,102,637	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.33	10,513	4,200	13,986		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.59	1,417	2,100	1,239		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.92	11,930		15,225	15,225	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.92	11,930			15,225	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,613,752	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					150	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,613,902	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999907	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					343,619	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,019,060	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,362,679	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,362,679	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,362,552	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,976,304	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-8630 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.95	1,954	2,100	1,995		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.95	1,954		1,995	1,995	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.95	1,954			1,995	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					231,247	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,046	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					232,293	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995497	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					285,810	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					203,714	15.00
16.00	Total overhead (sum of lines 14 and 15)					489,524	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					489,524	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					487,320	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					718,567	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	17.33	48,410	4,200	72,786		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	9.23	15,160	2,100	19,383		3.00
4.00	Subtotal (sum of lines 1 through 3)	26.56	63,570		92,169	92,169	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	11.05	10,905			10,905	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	37.61	74,475			103,074	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					11,021,173	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,065,633	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					12,086,806	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.911835	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,247,864	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					7,838,154	15.00
16.00	Total overhead (sum of lines 14 and 15)					9,086,018	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					9,086,018	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					8,284,949	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					19,306,122	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-8634 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.15	14,991	2,100	8,715		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.15	14,991		8,715	14,991	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.15	14,991			14,991	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,030,691	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,030,691	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					496,482	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					558,969	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,055,451	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,055,451	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,055,451	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,086,142	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 14-8635 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC VI Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.67	10,803	4,200	11,214		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.84	14,605	2,100	8,064		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.51	25,408		19,278	25,408	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.51	25,408			25,408	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,816,963	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,816,963	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					135,263	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,373,285	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,508,548	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,508,548	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,508,548	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,325,511	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VII | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	5.86	15,170	4,200	24,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.32	6,440	2,100	4,872		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.18	21,610		29,484	29,484	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.18	21,610			29,484	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,084,783	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5,995	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,090,778	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998060	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					148,686	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,552,097	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,700,783	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,700,783	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,697,483	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,782,266	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 26-8801 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC VIII | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.34	2,111	4,200	1,428		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.18	1,601	2,100	378		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.52	3,712		1,806	3,712	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.52	3,712			3,712	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					273,253	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					273,253	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					94,632	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					125,169	15.00
16.00	Total overhead (sum of lines 14 and 15)					219,801	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					219,801	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					219,801	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					493,054	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Component CCN: 26-8802 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 12/29/2023 3:54 pm

RHC IX | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.14	376	4,200	588		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.17	244	2,100	357		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.31	620		945	945	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.31	620			945	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					102,830	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					102,830	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					34,877	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					47,289	15.00
16.00	Total overhead (sum of lines 14 and 15)					82,166	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					82,166	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					82,166	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					184,996	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,102,637	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			62,345	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,040,292	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,513	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,513	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			188.70	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	330	872		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	37,290	109,872		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	2		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	252		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	252		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	147,414		16.00
16.01	Total program charges (see instructions)(from contractor's records)		223,190		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		33,255		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		21,965		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		83,307		16.04
16.05	Total program cost (see instructions)	0	105,272		16.05
17.00	Primary payer amounts		267		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,315		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		105,005		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,287		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		127,292		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		127,292		26.00
26.01	Sequestration adjustment (see instructions)		2,546		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		100,787		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		23,959		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-8629	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,976,304	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			145,441	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,830,863	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,225	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,225	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			185.94	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	729	2,091		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	82,377	263,466		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	345,843		16.00
16.01	Total program charges (see instructions)(from contractor's records)		548,722		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		167,976		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		105,870		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		158,201		16.04
16.05	Total program cost (see instructions)	0	264,071		16.05
17.00	Primary payer amounts		82		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,222		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		263,989		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		48,426		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		312,415		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		312,415		26.00
26.01	Sequestration adjustment (see instructions)		6,248		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		254,198		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		51,969		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-8630	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		718,567	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		10,664	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		707,903	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,995	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,995	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		354.84	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	51	192	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	5,763	24,192	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	29,955	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,865	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,722	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,225	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		18,539	16.04
16.05	Total program cost (see instructions)	0	21,764	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,556	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		21,764	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,506	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		25,270	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		25,270	26.00
26.01	Sequestration adjustment (see instructions)		505	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		21,020	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,745	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-8631	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			19,306,122	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			883,187	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			18,422,935	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			103,074	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			103,074	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			178.74	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,696	4,785		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	191,648	602,910		11.00
12.00	Program covered visits for mental health services (from contractor records)	208	668		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	23,504	84,168		13.00
14.00	Limit adjustment for mental health services (see instructions)	23,504	84,168		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	902,230		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,522,313		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		143,789		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		85,219		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		548,072		16.04
16.05	Total program cost (see instructions)	0	633,291		16.05
17.00	Primary payer amounts		271		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		131,921		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		633,020		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		44,632		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		677,652		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		677,652		26.00
26.01	Sequestration adjustment (see instructions)		13,553		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		617,499		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		46,600		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-8634	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,086,142	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		145,256	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,940,886	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,991	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		14,991	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		129.47	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	228	428	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	25,764	53,928	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	79,692	16.00
16.01	Total program charges (see instructions)(from contractor's records)		84,215	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		28,630	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		27,092	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		33,378	16.04
16.05	Total program cost (see instructions)	0	60,470	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,877	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,470	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		48,848	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		109,318	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		109,318	26.00
26.01	Sequestration adjustment (see instructions)		2,186	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		58,750	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		48,382	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-8635	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC VI	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,325,511	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,325,511	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			25,408	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			25,408	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			170.24	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	259	825		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	29,267	103,950		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	133,217		16.00
16.01	Total program charges (see instructions)(from contractor's records)		195,751		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,745		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,271		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		87,382		16.04
16.05	Total program cost (see instructions)	0	92,653		16.05
17.00	Primary payer amounts		66		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,718		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		92,587		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		92,587		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		92,587		26.00
26.01	Sequestration adjustment (see instructions)		1,852		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		90,351		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		384		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 26-8800	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC VII	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,782,266	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			204,801	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,577,465	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29,484	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			29,484	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			155.25	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	7		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	882		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	882		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,256		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		-299		16.04
16.05	Total program cost (see instructions)	0	-299		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,256		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		-299		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		52,333		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		52,034		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		52,034		26.00
26.01	Sequestration adjustment (see instructions)		1,041		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		0		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		50,993		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 26-8801	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	RHC VIII	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		493,054	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		15,589	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		477,465	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,712	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,712	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		128.63	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,327	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		9,327	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		9,327	26.00
26.01	Sequestration adjustment (see instructions)		187	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		9,140	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	471,931	471,931	471,931	471,931	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000499	0.003842	0.001796	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	235	1,813	848	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,497	12,203	10,247	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,732	14,016	11,095	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	616,236	616,236	616,236	616,236	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	486,401	486,401	486,401	486,401	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015793	0.022745	0.018004	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,682	11,063	8,757	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,414	25,079	19,852	0	10.00
11.00	Total number of injections/infusions (from your records)	50	385	90	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	348.28	65.14	220.58	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	18	124	36	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,269	8,077	7,941	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		62,345	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		22,287	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-8629 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,613,752	1,613,752	1,613,752	1,613,752	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000733	0.003627	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,183	5,853	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	40,885	30,938	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	42,068	36,791	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,613,752	1,613,752	1,613,752	1,613,752	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,362,552	1,362,552	1,362,552	1,362,552	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026068	0.022798	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	35,519	31,063	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	77,587	67,854	0	0	10.00
11.00	Total number of injections/infusions (from your records)	183	905	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	423.97	74.98	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	67	267	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	28,406	20,020	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		145,441	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		48,426	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-8630 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	231,247	231,247	231,247	231,247	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000125	0.000958	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	29	222	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,398	1,783	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,427	2,005	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	231,247	231,247	231,247	231,247	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	487,320	487,320	487,320	487,320	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006171	0.008670	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,007	4,225	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,434	6,230	0	0	10.00
11.00	Total number of injections/infusions (from your records)	9	69	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	492.67	90.29	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	17	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,971	1,535	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)	10,664	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)	3,506	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-8631 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	11,021,173	11,021,173	11,021,173	11,021,173	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001172	0.002210	0.000010	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	12,917	24,357	110	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	386,187	80,498	114	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	399,104	104,855	224	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	11,021,173	11,021,173	11,021,173	11,021,173	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	8,284,949	8,284,949	8,284,949	8,284,949	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.036212	0.009514	0.000020	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	300,015	78,823	166	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	699,119	183,678	390	0	10.00
11.00	Total number of injections/infusions (from your records)	1,856	3,499	1	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	376.68	52.49	390.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	64	391	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	24,108	20,524	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		883,187	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		44,632	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-8634 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,030,691	1,030,691	1,030,691	1,030,691	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.005715	0.003147	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	5,890	3,244	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	29,502	33,130	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	35,392	36,374	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,030,691	1,030,691	1,030,691	1,030,691	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,055,451	1,055,451	1,055,451	1,055,451	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.034338	0.035291	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	36,242	37,248	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	71,634	73,622	0	10.00
11.00	Total number of injections/infusions (from your records)	0	1,057	291	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	67.77	253.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	284	117	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	19,247	29,601	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		145,256	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		48,848	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 26-8800 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC VII | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,084,783	3,084,783	3,084,783	3,084,783	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001668	0.001298	0.000115	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,145	4,004	355	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	105,918	14,749	1,935	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	111,063	18,753	2,290	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,084,783	3,084,783	3,084,783	3,084,783	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,697,483	1,697,483	1,697,483	1,697,483	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.036004	0.006079	0.000742	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	61,116	10,319	1,260	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	172,179	29,072	3,550	0	10.00
11.00	Total number of injections/infusions (from your records)	495	385	17	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	347.84	75.51	208.82	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	112	155	8	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	38,958	11,704	1,671	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		204,801	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		52,333	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 26-8801 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC VIII | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	273,253	273,253	273,253	273,253	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000552	0.001214	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	151	332	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,740	2,416	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,891	2,748	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	273,253	273,253	273,253	273,253	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	219,801	219,801	219,801	219,801	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.021559	0.010057	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,739	2,211	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10,630	4,959	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	55	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	425.20	90.16	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	28	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,803	2,524	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		15,589	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		9,327	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0015 | Component CCN: 26-8802 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 12/29/2023 3:54 pm

Title XVIII | RHC IX | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	102,830	102,830	102,830	102,830	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002141	0.004818	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	220	495	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,601	1,052	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,821	1,547	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	102,830	102,830	102,830	102,830	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	82,166	82,166	82,166	82,166	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.017709	0.015044	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,455	1,236	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,276	2,783	0	0	10.00
11.00	Total number of injections/infusions (from your records)	12	27	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	273.00	103.07	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	6	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	546	618	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		6,059	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,164	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		100,787	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		100,787	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		23,959	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		124,746	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-8629	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		252,530	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		05/31/2023	1,668	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,668	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		254,198	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		51,969	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		306,167	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-8630	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		21,020	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		21,020	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		3,745	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		24,765	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-8631	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		612,248	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		05/31/2023	5,251	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,251	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		617,499	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		46,600	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		664,099	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-8634	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		58,750	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		58,750	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		48,382	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		107,132	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-8635	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		90,351	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		90,351	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		384	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		90,735	7.00

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