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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/12/2023 10:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
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 Community Health Network Rehab Hosp (15-3043) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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				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				2
3	Signatory Title	CEO			3
4	Date				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	8,005	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	8,005	0	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 674 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/12/2023 10:47 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7343 Clearvista Drive	PO Box:			1.00
2.00	City: Indianapolis	State: IN	Zip Code: 46256	County: Marion	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	Community Health Network Rehab Hosp	153043	26900	5	07/16/2013	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
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)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	5		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/12/2023 10:47 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	108	315	0	0	1,860		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.	1		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.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/12/2023 10:47 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/12/2023 10:47 am

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/12/2023 10:47 am

		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	
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)?	N					68.00

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

		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.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/12/2023 10:47 am

		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.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/12/2023 10:47 am

		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
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	188,557	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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.			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
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	HB0616	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/12/2023 10:47 am

	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: LIFEPIONT HEALTH	Contractor's Name: PALMETTOA GBA	Contractor's Number: 10001	141.00
142.00	Street: 330 SEVEN SPRINGS WAY	PO Box:		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	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
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03

		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.	N	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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/12/2023 10:47 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost 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	03/31/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/28/2023	Y	02/28/2023	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/12/2023 10:47 am

		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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	SIMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	LIFEPOINT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945	DAVID.SIMPSON@LIFEPOINTHEALTH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/12/2023 10:47 am

		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 MANAGER		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

VOLUNTARY CONTACT INFORMATION | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part V | Date/Time Prepared: 5/12/2023 10:47 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name	DAVID	1.00
2.00	Last Name	SIMPSON	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	LIFEPOINT HEALTH	4.00
5.00	Phone Number	(502)596-7945	5.00
6.00	E-mail Address	DAVID.SIMPSON@LIFEPOINTHEALTH.NET	6.00
7.00	Department	REIMBURSEMENT	7.00
8.00	Mailing Address 1	680 SOUTH FOURTH STREET	8.00
9.00	Mailing Address 2	ATTN: REIMBURSEMENT	9.00
10.00	City	LOUISVILLE	10.00
11.00	State	KY	11.00
12.00	Zip	40202	12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	ANNETTE	13.00
14.00	Last Name	SEABROOK	14.00
15.00	Title	CEO	15.00
16.00	Employer		16.00
17.00	Phone Number	(317)585-5401	17.00
18.00	E-mail Address	ASEABROOK@CHREHABNORTH.COM	18.00
19.00	Department		19.00
20.00	Mailing Address 1	7343 CLEARVISTA DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	INDIANPOLIS	22.00
23.00	State	IN	23.00
24.00	Zip	46256	24.00

HFS Supplemental Information | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part IX Date/Time Prepared: 5/12/2023 10:47 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
	STATE MEDICAID FORMS			
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/12/2023 10:47 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH 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	60	21,900	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)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		60	21,900	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		60				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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/12/2023 10:47 am

	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)	8,109	108	18,825			1.00
2.00	HMO and other (see instructions)	2,544	2,175				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	8,109	108	18,825			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	8,109	108	18,825	0.00	134.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	134.70	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/12/2023 10:47 am

	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	710	8	1,605	1.00
2.00	HMO and other (see instructions)			207	190		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	710	8	1,605	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/12/2023 10:47 am

		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	10,789,174	0	10,789,174	280,412.00	38.48	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	820,085	820,085	21,468.00	38.20	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,696,550	0	4,696,550	70,874.00	66.27	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		145,440	0	145,440	808.00	180.00	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		1,793,371	0	1,793,371	29,501.00	60.79	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)		1,602,311	0	1,602,311			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		131,811	0	131,811			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 5/12/2023 10:47 am

		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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	845,210	0	845,210	22,141.00	38.17	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	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	388,805	0	388,805	14,865.00	26.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	499,164	0	499,164	22,641.00	22.05	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	408,969	0	408,969	8,226.00	49.72	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	367,386	0	367,386	6,520.00	56.35	40.00
41.00	Medical Records & Medical Records Library	16.00	449,335	0	449,335	11,461.00	39.21	41.00
42.00	Social Service	17.00	820,085	-820,085	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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/12/2023 10:47 am

		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)		10,789,174	0	10,789,174	280,412.00	38.48	1.00
2.00	Excluded area salaries (see instructions)		0	820,085	820,085	21,468.00	38.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)		10,789,174	-820,085	9,969,089	258,944.00	38.50	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,635,361	0	6,635,361	101,183.00	65.58	4.00
5.00	Subtotal wage-related costs (see inst.)		1,602,311	0	1,602,311	0.00	16.07	5.00
6.00	Total (sum of lines 3 thru 5)		19,026,846	-820,085	18,206,761	360,127.00	50.56	6.00
7.00	Total overhead cost (see instructions)		3,778,954	-820,085	2,958,869	85,854.00	34.46	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/12/2023 10:47 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	19,373	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	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)	653,833	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	46	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,549	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)	52,634	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	108,864	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	736,430	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	20,773	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	4,809	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,602,311	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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 5/12/2023 10:47 am

	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	4,696,550	1,602,311	1.00
2.00	Hospital	4,696,550	1,602,311	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			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	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
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	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/12/2023 10:47 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.369928	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	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	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	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 (line 11 minus line 9; if < zero then enter zero)	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 (line 15 minus line 13; if < zero then enter zero)	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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 (line 21 minus line 22)	0	0	0	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	0	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	15,036	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	23,133	27.01
28.00	Non-Medicare bad debt expense (see instructions)	-23,133	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	-461	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	-461	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	-461	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/12/2023 10:47 am

		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		1,759,100	1,759,100	5,452	1,764,552	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		77,920	77,920	352,505	430,425	2.00
3.00	00300	OTHER CAP REL COSTS		357,957	357,957	-357,957	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,869,463	1,869,463	143	1,869,606	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	845,210	3,804,876	4,650,086	-455,216	4,194,870	5.00
7.00	00700	OPERATION OF PLANT	0	453,919	453,919	3,916	457,835	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,386	101,386	0	101,386	8.00
9.00	00900	HOUSEKEEPING	388,805	47,547	436,352	0	436,352	9.00
10.00	01000	DIETARY	499,164	351,558	850,722	0	850,722	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	408,969	251,185	660,154	-57,524	602,630	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,791	6,791	190,125	196,916	14.00
15.00	01500	PHARMACY	367,386	172,218	539,604	26,375	565,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	449,335	2,426	451,761	0	451,761	16.00
17.00	01700	SOCIAL SERVICE	820,085	7,681	827,766	-827,766	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,937,352	4,815,334	8,752,686	325,067	9,077,753	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,543	76,543	285,631	362,174	54.00
60.00	06000	LABORATORY	0	109,829	109,829	-120,375	-10,546	60.00
65.00	06500	RESPIRATORY THERAPY	113,809	40,807	154,616	1,182	155,798	65.00
66.00	06600	PHYSICAL THERAPY	1,404,247	37,107	1,441,354	761	1,442,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,182,537	233	1,182,770	0	1,182,770	67.00
68.00	06800	SPEECH PATHOLOGY	372,275	452	372,727	0	372,727	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	389,960	389,960	-199,982	189,978	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	347,711	347,711	-103	347,608	73.00
74.00	07400	RENAL DIALYSIS	0	19,036	19,036	0	19,036	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	117,390	117,390	0	117,390	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,789,174	15,218,429	26,007,603	-827,766	25,179,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	827,766	827,766	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	10,789,174	15,218,429	26,007,603	0	26,007,603	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/12/2023 10:47 am

		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	-22,649	1,741,903		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-20,517	409,908		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-335,055	1,534,551		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,517,447	6,712,317		5.00
7.00	00700	OPERATION OF PLANT	-1,732	456,103		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,386		8.00
9.00	00900	HOUSEKEEPING	0	436,352		9.00
10.00	01000	DIETARY	-15,546	835,176		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	602,630		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	196,916		14.00
15.00	01500	PHARMACY	0	565,979		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-298	451,463		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	144,472	9,222,225		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	362,174		54.00
60.00	06000	LABORATORY	0	-10,546		60.00
65.00	06500	RESPIRATORY THERAPY	0	155,798		65.00
66.00	06600	PHYSICAL THERAPY	0	1,442,115		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,182,770		67.00
68.00	06800	SPEECH PATHOLOGY	0	372,727		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	189,978		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	347,608		73.00
74.00	07400	RENAL DIALYSIS	0	19,036		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-117,390	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,148,732	27,328,569		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	827,766		194.00
194.01	07951	IDLE SPACE	0	0		194.01
194.02	07952	DISTRICT	0	0		194.02
194.03	07953	DISTRICT SALES	0	0		194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0		194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0		194.05
194.06	07956	CENTRALIZED STAFFING	0	0		194.06
194.07	07957	HR MANAGED CARE	0	0		194.07
194.08	07959	LACUNA HEALTH	0	0		194.08
194.09	07958	SALES & MARKETING	0	0		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		194.11
194.12	07960	VISITOR MEALS	0	0		194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	2,148,732	28,156,335		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet Non-CMS W | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	09850		98.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	NONALLOWABLE CASE MANAGER	07950		194.00
194.01	IDLE SPACE	07951		194.01
194.02	DISTRICT	07952		194.02
194.03	DISTRICT SALES	07953		194.03
194.04	CENTRALIZED ADMISSIONS (CAD)	07954		194.04
194.05	CENTRALIZED BUSINESS (CBO)	07955		194.05
194.06	CENTRALIZED STAFFING	07956		194.06
194.07	HR MANAGED CARE	07957		194.07
194.08	LACUNA HEALTH	07959		194.08
194.09	SALES & MARKETING	07958		194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS	07962		194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATION	07961		194.11
194.12	VISITOR MEALS	07960		194.12
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/12/2023 10:47 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER					
1.00	NONALLOWABLE CASE MANAGER	194.00	820,085	7,681		1.00
	TOTALS		820,085	7,681		
	B - RECLASS RELATED PARTY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	143		1.00
2.00	OPERATION OF PLANT	7.00	0	3,916		2.00
3.00	PHARMACY	15.00	0	26,375		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	215,865		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	285,631		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	2		6.00
	TOTALS		0	531,932		
	C - RECLASS PURCHASED SERVICE EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	103,881		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	103,881		
	D - RECLASS NON-CHARGEABLE MED SUPPLY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,750		1.00
2.00	NURSING ADMINISTRATION	13.00	0	843		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	190,125		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	5,321		4.00
5.00	RESPIRATORY THERAPY	65.00	0	1,182		5.00
6.00	PHYSICAL THERAPY	66.00	0	761		6.00
	TOTALS		0	199,982		
500.00	Grand Total: Increases		820,085	843,476		500.00

RECLASSIFICATIONS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/12/2023 10:47 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	820,085	7,681	0		1.00
	TOTALS		820,085	7,681			
	B - RECLASS RELATED PARTY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	456,966	0		1.00
2.00	LABORATORY	60.00	0	74,861	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	105	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
	TOTALS		0	531,932			
	C - RECLASS PURCHASED SERVICE EXPENSE						
1.00	NURSING ADMINISTRATION	13.00	0	58,367	0		1.00
2.00	LABORATORY	60.00	0	45,514	0		2.00
	TOTALS		0	103,881			
	D - RECLASS NON-CHARGEABLE MED SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	199,982	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	199,982			
500.00	Grand Total: Decreases		820,085	843,476			500.00

RECLASSIFICATIONS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/12/2023 10:47 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS NON ALLOWABLE CASE MANAGER								
1.00	NONALLOWABLE CASE MANAGER	194.00	820,085	7,681	SOCIAL SERVICE	17.00	820,085	7,681	1.00
	TOTALS		820,085	7,681	TOTALS		820,085	7,681	
	B - RECLASS RELATED PARTY								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	143	ADMINISTRATIVE & GENERAL	5.00	0	456,966	1.00
2.00	OPERATION OF PLANT	7.00	0	3,916	LABORATORY	60.00	0	74,861	2.00
3.00	PHARMACY	15.00	0	26,375	DRUGS CHARGED TO PATIENTS	73.00	0	105	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	215,865		0.00	0	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	285,631		0.00	0	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	2		0.00	0	0	6.00
	TOTALS		0	531,932	TOTALS		0	531,932	
	C - RECLASS PURCHASED SERVICE EXPENSE								
1.00	ADULTS & PEDIATRICS	30.00	0	103,881	NURSING ADMINISTRATION	13.00	0	58,367	1.00
2.00		0.00	0	0	LABORATORY	60.00	0	45,514	2.00
	TOTALS		0	103,881	TOTALS		0	103,881	
	D - RECLASS NON-CHARGEABLE MED SUPPLY								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,750	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	199,982	1.00
2.00	NURSING ADMINISTRATION	13.00	0	843		0.00	0	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	190,125		0.00	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	5,321		0.00	0	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	1,182		0.00	0	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	761		0.00	0	0	6.00
	TOTALS		0	199,982	TOTALS		0	199,982	
500.00	Grand Total: Increases		820,085	843,476	Grand Total: Decreases		820,085	843,476	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/12/2023 10:47 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	10,041	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	616,076	33,143	0	33,143	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	626,117	33,143	0	33,143	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	626,117	33,143	0	33,143	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	10,041	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	649,219	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	659,260	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	659,260	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/12/2023 10:47 am

	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	1,453	1,757,647	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	73,380	4,540	0	0	0	2.00
3.00	Total (sum of lines 1-2)	74,833	1,762,187	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	1,759,100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	77,920		2.00
3.00	Total (sum of lines 1-2)	0	1,837,020		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	10,041	0	10,041	0.015231	1,428	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	649,219	0	649,219	0.984769	92,350	2.00
3.00	Total (sum of lines 1-2)	659,260	0	659,260	1.000000	93,778	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	4,024	0	5,452	1,453	1,757,647	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	260,155	0	352,505	52,863	4,540	2.00
3.00	Total (sum of lines 1-2)	264,179	0	357,957	54,316	1,762,187	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-21,221	4,024	0	1,741,903	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	92,350	260,155	0	409,908	2.00
3.00	Total (sum of lines 1-2)	0	71,129	264,179	0	2,151,811	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/12/2023 10:47 am

	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
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)	B	-999	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-969	ADMINISTRATIVE & GENERAL	5.00	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	-3,635	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,732	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,958			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	2,780,213			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-13,870	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-298	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,676	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** 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
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/12/2023 10:47 am

	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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-9,635	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-23,133	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-1,197	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-22,719	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-19,303	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-20,887	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	MARKETING BONUS	A	-13,207	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.33
33.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/12/2023 10:47 am

	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	
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.39
33.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.40
33.41	NON ALLOW AMBULANCE COSTS	A	-117,390	AMBULANCE SERVICES	95.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-22,649	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-20,517	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.04
34.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
34.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.06
34.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.07
34.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.08
34.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.09
34.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.10
34.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.11
34.12	NON ALLOWABLE LOBBYING FEES	A	-652	ADMINISTRATIVE & GENERAL	5.00	0	34.12
34.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.18
34.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.19
34.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.20
34.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.21
34.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.22
34.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.23
34.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.24
34.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.25
34.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.26
34.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.27
34.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.28
34.40	NONALLOWABLE VEBA EXPENSE	A	-707,576	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.40

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/12/2023 10:47 am

	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	
34.41	ALLOWABLE VEBA CLAIMS	A	372,521	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.41
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	PHYSICIAN FEE ADJUSTMENT	A	-146,430	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
35.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.04
35.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.07
35.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.08
35.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	146,430	ADULTS & PEDIATRICS	30.00	0	35.11
35.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.12
35.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.13
35.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.14
35.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.15
35.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.16
35.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.17
35.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.18
35.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.19
35.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.20
35.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.21
35.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.22
35.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.23
35.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.24
35.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,148,732				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/12/2023 10:47 am

	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	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	4,766,063	1,985,850	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
4.05	1.00	CAP REL COSTS-BLDG & FIXT	Hospital Related services	62,183	62,183	4.05
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	Hospital Related services	143	143	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Hospital Related services	64,609	64,609	4.09
4.10	7.00	OPERATION OF PLANT	Hospital Related services	3,916	3,916	4.10
4.17	15.00	PHARMACY	Hospital Related services	26,375	26,375	4.17
4.20	30.00	ADULTS & PEDIATRICS	Hospital Related services	215,865	215,865	4.20
4.26	54.00	RADIOLOGY-DIAGNOSTIC	Hospital Related services	330,164	330,164	4.26
4.33	73.00	DRUGS CHARGED TO PATIENTS	Hospital Related services	80	80	4.33
5.00	0		0	5,469,398	2,689,185	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	B		49.00	LIFEPOINT HEALT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00	B		51.00	Community Hlth Network	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/12/2023 10:47 am

	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	2,780,213	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.05	0	10		4.05
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.17	0	0		4.17
4.20	0	0		4.20
4.26	0	0		4.26
4.33	0	0		4.33
5.00	2,780,213			5.00

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

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

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

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

6.00	Home Office Cost		6.00
7.00			7.00
8.00			8.00
9.00	Hospital Services		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/12/2023 10:47 am

	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	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	4,500	0	4,500	211,500	25	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,500	0	4,500		25	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	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	2,542	127	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,542	127	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	30.00	DR. B	0	2,542	1,958	1,958		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	2,542	1,958	1,958		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,741,903	1,741,903				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	409,908		409,908			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,534,551	0	0	1,534,551		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,712,317	62,543	14,718	120,215	6,909,793	5.00
7.00	00700	OPERATION OF PLANT	456,103	57,696	13,577	0	527,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,386	20,303	4,778	0	126,467	8.00
9.00	00900	HOUSEKEEPING	436,352	8,753	2,060	55,300	502,465	9.00
10.00	01000	DIETARY	835,176	112,622	26,502	70,997	1,045,297	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	602,630	13,295	3,129	58,168	677,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	196,916	0	0	0	196,916	14.00
15.00	01500	PHARMACY	565,979	1,911	450	52,254	620,594	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	451,463	2,770	652	63,909	518,794	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,222,225	1,257,512	295,920	560,010	11,335,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	362,174	0	0	0	362,174	54.00
60.00	06000	LABORATORY	-10,546	31,299	7,365	0	28,118	60.00
65.00	06500	RESPIRATORY THERAPY	155,798	2,770	652	16,187	175,407	65.00
66.00	06600	PHYSICAL THERAPY	1,442,115	64,704	15,226	199,727	1,721,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,182,770	62,792	14,776	168,193	1,428,531	67.00
68.00	06800	SPEECH PATHOLOGY	372,727	35,205	8,284	52,949	469,165	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,978	0	0	0	189,978	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,608	0	0	0	347,608	73.00
74.00	07400	RENAL DIALYSIS	19,036	0	0	0	19,036	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,328,569	1,734,175	408,089	1,417,909	27,202,380	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	827,766	0	0	116,642	944,408	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	7,728	1,819	0	9,547	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,156,335	1,741,903	409,908	1,534,551	28,156,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,909,793					5.00
7.00	00700	OPERATION OF PLANT	171,513	698,889				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,130	8,750	176,347			8.00
9.00	00900	HOUSEKEEPING	163,412	3,772	0	669,649		9.00
10.00	01000	DIETARY	339,951	48,537	0	47,355	1,481,140	10.00
11.00	01100	CAFETERIA	0	0	0	0	102,662	11.00
13.00	01300	NURSING ADMINISTRATION	220,246	5,730	0	5,590	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,041	0	0	0	0	14.00
15.00	01500	PHARMACY	201,830	824	0	804	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168,722	1,194	0	1,165	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,686,577	541,950	176,347	528,748	1,369,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,786	0	0	0	0	54.00
60.00	06000	LABORATORY	9,145	13,489	0	13,161	0	60.00
65.00	06500	RESPIRATORY THERAPY	57,046	1,194	0	1,165	0	65.00
66.00	06600	PHYSICAL THERAPY	559,955	27,885	0	27,206	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	464,587	27,062	0	26,403	0	67.00
68.00	06800	SPEECH PATHOLOGY	152,582	15,172	0	14,803	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,785	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,049	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,191	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,599,548	695,559	176,347	666,400	1,471,686	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	307,140	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	3,105	3,330	0	3,249	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	9,454	194.12
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)	6,909,793	698,889	176,347	669,649	1,481,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	102,662					11.00
13.00	01300	NURSING ADMINISTRATION	3,838	912,626				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	260,957			14.00
15.00	01500	PHARMACY	2,878	0	2,170	829,100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,757	0	12,929	0	708,561	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,284	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,648	912,626	3,321	0	343,613	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	7,833	54.00
60.00	06000	LABORATORY	0	0	0	0	11,576	60.00
65.00	06500	RESPIRATORY THERAPY	1,919	0	0	13,762	1,199	65.00
66.00	06600	PHYSICAL THERAPY	16,311	0	0	0	107,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,473	0	0	0	127,442	67.00
68.00	06800	SPEECH PATHOLOGY	3,838	0	3,262	0	57,443	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	237,991	0	104	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	815,338	47,943	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,852	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,662	912,626	260,957	829,100	708,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	102,662	912,626	260,957	829,100	708,561	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,284					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,284	0	18,954,805	0	18,954,805	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	487,793	0	487,793	54.00
60.00	06000	LABORATORY	0	0	75,489	0	75,489	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	251,692	0	251,692	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,460,685	0	2,460,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,086,498	0	2,086,498	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	716,265	0	716,265	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	489,858	0	489,858	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,323,938	0	1,323,938	73.00
74.00	07400	RENAL DIALYSIS	0	0	29,079	0	29,079	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,284	0	26,876,102	0	26,876,102	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	1,251,548	0	1,251,548	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	19,231	0	19,231	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	9,454	0	9,454	194.12
200.00		Cross Foot Adjustments		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)	1,284	0	28,156,335	0	28,156,335	202.00

COST ALLOCATION STATISTICS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet Non-CMS W | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET #1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET #2	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	7	SQUARE FEET #3	7.00
8.00	LAUNDRY & LINEN SERVICE	P	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	9	SQUARE FEET #4	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	CAFETERIA FTES	11.00
13.00	NURSING ADMINISTRATION	13	NURSING FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	P	PATIENT DAYS	17.00
23.00	PARAMED ED PRGM-(SPECIFY)	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	701,564	62,543	14,718	778,825	0	5.00
7.00	00700	OPERATION OF PLANT	0	57,696	13,577	71,273	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,303	4,778	25,081	0	8.00
9.00	00900	HOUSEKEEPING	0	8,753	2,060	10,813	0	9.00
10.00	01000	DIETARY	0	112,622	26,502	139,124	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,295	3,129	16,424	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,911	450	2,361	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,770	652	3,422	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,257,512	295,920	1,553,432	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	31,299	7,365	38,664	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,770	652	3,422	0	65.00
66.00	06600	PHYSICAL THERAPY	0	64,704	15,226	79,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62,792	14,776	77,568	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,205	8,284	43,489	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	701,564	1,734,175	408,089	2,843,828	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	7,728	1,819	9,547	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	701,564	1,741,903	409,908	2,853,375	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	778,825					5.00
7.00	00700	OPERATION OF PLANT	19,332	90,605				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,636	1,134	30,851			8.00
9.00	00900	HOUSEKEEPING	18,419	489	0	29,721		9.00
10.00	01000	DIETARY	38,317	6,292	0	2,102	185,835	10.00
11.00	01100	CAFETERIA	0	0	0	0	12,881	11.00
13.00	01300	NURSING ADMINISTRATION	24,825	743	0	248	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,218	0	0	0	0	14.00
15.00	01500	PHARMACY	22,749	107	0	36	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,017	155	0	52	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	415,523	70,259	30,851	23,467	171,768	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,276	0	0	0	0	54.00
60.00	06000	LABORATORY	1,031	1,749	0	584	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,430	155	0	52	0	65.00
66.00	06600	PHYSICAL THERAPY	63,115	3,615	0	1,207	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,366	3,508	0	1,172	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,198	1,967	0	657	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,964	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,742	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	698	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	743,856	90,173	30,851	29,577	184,649	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	34,619	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	350	432	0	144	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	1,186	194.12
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)	778,825	90,605	30,851	29,721	185,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,881					11.00
13.00	01300	NURSING ADMINISTRATION	482	42,722				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,218			14.00
15.00	01500	PHARMACY	361	0	60	25,674		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	722	0	358	0	23,726	16.00
17.00	01700	SOCIAL SERVICE	0	0	36	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,981	42,722	92	0	11,491	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	263	54.00
60.00	06000	LABORATORY	0	0	0	0	388	60.00
65.00	06500	RESPIRATORY THERAPY	241	0	0	426	40	65.00
66.00	06600	PHYSICAL THERAPY	2,047	0	0	0	3,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,565	0	0	0	4,273	67.00
68.00	06800	SPEECH PATHOLOGY	482	0	90	0	1,926	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	6,582	0	3	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,248	1,607	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	129	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,881	42,722	7,218	25,674	23,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	12,881	42,722	7,218	25,674	23,726	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	36					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36		2,326,622	0	2,326,622	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		13,539	0	13,539	54.00
60.00	06000	LABORATORY	0		42,416	0	42,416	60.00
65.00	06500	RESPIRATORY THERAPY	0		10,766	0	10,766	65.00
66.00	06600	PHYSICAL THERAPY	0		153,520	0	153,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		140,452	0	140,452	67.00
68.00	06800	SPEECH PATHOLOGY	0		65,809	0	65,809	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		13,549	0	13,549	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		39,597	0	39,597	73.00
74.00	07400	RENAL DIALYSIS	0		827	0	827	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36	0	2,807,097	0	2,807,097	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0		34,619	0	34,619	194.00
194.01	07951	IDLE SPACE	0		0	0	0	194.01
194.02	07952	DISTRICT	0		0	0	0	194.02
194.03	07953	DISTRICT SALES	0		0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0		0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0		0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0		0	0	0	194.06
194.07	07957	HR MANAGED CARE	0		0	0	0	194.07
194.08	07959	LACUNA HEALTH	0		0	0	0	194.08
194.09	07958	SALES & MARKETING	0		10,473	0	10,473	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0		0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	0	0	194.11
194.12	07960	VISITOR MEALS	0		1,186	0	1,186	194.12
200.00		Cross Foot Adjustments		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)	36	0	2,853,375	0	2,853,375	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET #1)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	62,888					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		62,888				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,789,174			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,258	2,258	845,210	-6,909,793	21,246,542	5.00
7.00	00700	OPERATION OF PLANT	2,083	2,083	0	0	527,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	733	733	0	0	126,467	8.00
9.00	00900	HOUSEKEEPING	316	316	388,805	0	502,465	9.00
10.00	01000	DIETARY	4,066	4,066	499,164	0	1,045,297	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	480	408,969	0	677,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	196,916	14.00
15.00	01500	PHARMACY	69	69	367,386	0	620,594	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100	100	449,335	0	518,794	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,400	45,400	3,937,352	0	11,335,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	362,174	54.00
60.00	06000	LABORATORY	1,130	1,130	0	0	28,118	60.00
65.00	06500	RESPIRATORY THERAPY	100	100	113,809	0	175,407	65.00
66.00	06600	PHYSICAL THERAPY	2,336	2,336	1,404,247	0	1,721,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,267	2,267	1,182,537	0	1,428,531	67.00
68.00	06800	SPEECH PATHOLOGY	1,271	1,271	372,275	0	469,165	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	189,978	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	347,608	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	19,036	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,609	62,609	9,969,089	-6,909,793	20,292,587	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	820,085	0	944,408	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	279	279	0	0	9,547	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	1,741,903	409,908	1,534,551		6,909,793	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.698496	6.518064	0.142231		0.325220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		778,825	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.036657	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	58,547					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	733	18,825				8.00
9.00	00900	HOUSEKEEPING	316	0	57,498			9.00
10.00	01000	DIETARY	4,066	0	4,066	61,100		10.00
11.00	01100	CAFETERIA	0	0	0	4,235	107	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	4	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	69	0	69	0	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100	0	100	0	6	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,400	18,825	45,400	56,475	58	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	1,130	0	1,130	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	100	0	100	0	2	65.00
66.00	06600	PHYSICAL THERAPY	2,336	0	2,336	0	17	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,267	0	2,267	0	13	67.00
68.00	06800	SPEECH PATHOLOGY	1,271	0	1,271	0	4	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,268	18,825	57,219	60,710	107	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	279	0	279	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	390	0	194.12
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)	698,889	176,347	669,649	1,481,140	102,662	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.937230	9.367703	11.646475	24.241244	959.457944	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	90,605	30,851	29,721	185,835	12,881	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.547560	1.638831	0.516905	3.041489	120.383178	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	58					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,681				14.00
15.00	01500	PHARMACY	0	147	353,580			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	876	0	72,652,326		16.00
17.00	01700	SOCIAL SERVICE	0	87	0	0	18,825	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58	225	0	35,233,339	18,825	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	803,098	0	54.00
60.00	06000	LABORATORY	0	0	0	1,186,891	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,869	122,924	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,028,013	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,066,962	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	221	0	5,889,816	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,125	0	10,627	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	347,711	4,915,667	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	394,989	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58	17,681	353,580	72,652,326	18,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	912,626	260,957	829,100	708,561	1,284	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15,734.931034	14.759177	2.344872	0.009753	0.068207	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,722	7,218	25,674	23,726	36	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	736.586207	0.408235	0.072612	0.000327	0.001912	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/12/2023 10:47 am

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0		194.00
194.01	07951	IDLE SPACE	0		194.01
194.02	07952	DISTRICT	0		194.02
194.03	07953	DISTRICT SALES	0		194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0		194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0		194.05
194.06	07956	CENTRALIZED STAFFING	0		194.06
194.07	07957	HR MANAGED CARE	0		194.07
194.08	07959	LACUNA HEALTH	0		194.08
194.09	07958	SALES & MARKETING	0		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		194.11
194.12	07960	VISITOR MEALS	0		194.12
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		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		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	18,954,805		18,954,805	1,958	18,956,763	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,793		487,793	0	487,793	54.00
60.00	06000	LABORATORY	75,489		75,489	0	75,489	60.00
65.00	06500	RESPIRATORY THERAPY	251,692	0	251,692	0	251,692	65.00
66.00	06600	PHYSICAL THERAPY	2,460,685	0	2,460,685	0	2,460,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,086,498	0	2,086,498	0	2,086,498	67.00
68.00	06800	SPEECH PATHOLOGY	716,265	0	716,265	0	716,265	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	489,858		489,858	0	489,858	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,938		1,323,938	0	1,323,938	73.00
74.00	07400	RENAL DIALYSIS	29,079		29,079	0	29,079	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,233,339		35,233,339			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,098	0	803,098	0.607389	0.000000	54.00
60.00	06000	LABORATORY	1,186,891	0	1,186,891	0.063602	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	122,924	0	122,924	2.047542	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,028,013	0	11,028,013	0.223130	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,066,962	0	13,066,962	0.159677	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,889,816	0	5,889,816	0.121611	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,627	0	10,627	46.095606	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,915,667	0	4,915,667	0.269330	0.000000	73.00
74.00	07400	RENAL DIALYSIS	394,989	0	394,989	0.073620	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	72,652,326	0	72,652,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,652,326	0	72,652,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607389
60.00	06000	LABORATORY	0.063602
65.00	06500	RESPIRATORY THERAPY	2.047542
66.00	06600	PHYSICAL THERAPY	0.223130
67.00	06700	OCCUPATIONAL THERAPY	0.159677
68.00	06800	SPEECH PATHOLOGY	0.121611
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46.095606
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269330
74.00	07400	RENAL DIALYSIS	0.073620
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.000000
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		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	18,954,805		18,954,805	1,958	18,956,763	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,793		487,793	0	487,793	54.00
60.00	06000	LABORATORY	75,489		75,489	0	75,489	60.00
65.00	06500	RESPIRATORY THERAPY	251,692	0	251,692	0	251,692	65.00
66.00	06600	PHYSICAL THERAPY	2,460,685	0	2,460,685	0	2,460,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,086,498	0	2,086,498	0	2,086,498	67.00
68.00	06800	SPEECH PATHOLOGY	716,265	0	716,265	0	716,265	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	489,858		489,858	0	489,858	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,938		1,323,938	0	1,323,938	73.00
74.00	07400	RENAL DIALYSIS	29,079		29,079	0	29,079	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,233,339		35,233,339			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,098	0	803,098	0.607389	0.000000	54.00
60.00	06000	LABORATORY	1,186,891	0	1,186,891	0.063602	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	122,924	0	122,924	2.047542	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,028,013	0	11,028,013	0.223130	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,066,962	0	13,066,962	0.159677	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,889,816	0	5,889,816	0.121611	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,627	0	10,627	46.095606	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,915,667	0	4,915,667	0.269330	0.000000	73.00
74.00	07400	RENAL DIALYSIS	394,989	0	394,989	0.073620	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	72,652,326	0	72,652,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,652,326	0	72,652,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607389
60.00	06000	LABORATORY	0.063602
65.00	06500	RESPIRATORY THERAPY	2.047542
66.00	06600	PHYSICAL THERAPY	0.223130
67.00	06700	OCCUPATIONAL THERAPY	0.159677
68.00	06800	SPEECH PATHOLOGY	0.121611
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46.095606
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269330
74.00	07400	RENAL DIALYSIS	0.073620
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.000000
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

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	18,954,805		18,954,805	1,958	18,956,763	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,793		487,793	0	487,793	54.00
60.00	06000	LABORATORY	75,489		75,489	0	75,489	60.00
65.00	06500	RESPIRATORY THERAPY	251,692	0	251,692	0	251,692	65.00
66.00	06600	PHYSICAL THERAPY	2,460,685	0	2,460,685	0	2,460,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,086,498	0	2,086,498	0	2,086,498	67.00
68.00	06800	SPEECH PATHOLOGY	716,265	0	716,265	0	716,265	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	489,858		489,858	0	489,858	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,938		1,323,938	0	1,323,938	73.00
74.00	07400	RENAL DIALYSIS	29,079		29,079	0	29,079	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,876,102	0	26,876,102	1,958	26,878,060	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

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	35,233,339		35,233,339			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,098	0	803,098	0.607389	0.000000	54.00
60.00	06000	LABORATORY	1,186,891	0	1,186,891	0.063602	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	122,924	0	122,924	2.047542	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,028,013	0	11,028,013	0.223130	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,066,962	0	13,066,962	0.159677	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,889,816	0	5,889,816	0.121611	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,627	0	10,627	46.095606	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,915,667	0	4,915,667	0.269330	0.000000	73.00
74.00	07400	RENAL DIALYSIS	394,989	0	394,989	0.073620	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	72,652,326	0	72,652,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,652,326	0	72,652,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/12/2023 10:47 am

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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/12/2023 10:47 am

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	2,326,622	0	2,326,622	18,825	123.59	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,326,622		2,326,622	18,825		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	8,109	1,002,191	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	8,109	1,002,191	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,539	803,098	0.016858	247,686	4,175	54.00
60.00	06000	LABORATORY	42,416	1,186,891	0.035737	490,410	17,526	60.00
65.00	06500	RESPIRATORY THERAPY	10,766	122,924	0.087583	49,803	4,362	65.00
66.00	06600	PHYSICAL THERAPY	153,520	11,028,013	0.013921	4,948,901	68,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,452	13,066,962	0.010749	5,624,068	60,453	67.00
68.00	06800	SPEECH PATHOLOGY	65,809	5,889,816	0.011173	2,380,628	26,599	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,549	10,627	1.274960	801	1,021	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,597	4,915,667	0.008055	1,999,522	16,106	73.00
74.00	07400	RENAL DIALYSIS	827	394,989	0.002094	114,454	240	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	480,475	37,418,987		15,856,273	199,376	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,825	0.00	8,109	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	18,825		8,109	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	803,098	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,186,891	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	122,924	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,028,013	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,066,962	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,889,816	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,627	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,915,667	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	394,989	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	37,418,987		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/12/2023 10:47 am

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	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	247,686	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	490,410	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	49,803	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,948,901	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,624,068	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,380,628	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	801	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,999,522	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	114,454	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		15,856,273	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/12/2023 10:47 am

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	2,326,622	0	2,326,622	18,825	123.59	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,326,622		2,326,622	18,825		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	8,109	1,002,191	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	8,109	1,002,191	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,539	803,098	0.016858	247,686	4,175	54.00
60.00	06000	LABORATORY	42,416	1,186,891	0.035737	490,410	17,526	60.00
65.00	06500	RESPIRATORY THERAPY	10,766	122,924	0.087583	49,803	4,362	65.00
66.00	06600	PHYSICAL THERAPY	153,520	11,028,013	0.013921	4,948,901	68,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,452	13,066,962	0.010749	5,624,068	60,453	67.00
68.00	06800	SPEECH PATHOLOGY	65,809	5,889,816	0.011173	2,380,628	26,599	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,549	10,627	1.274960	801	1,021	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,597	4,915,667	0.008055	1,999,522	16,106	73.00
74.00	07400	RENAL DIALYSIS	827	394,989	0.002094	114,454	240	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	480,475	37,418,987		15,856,273	199,376	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,825	0.00	8,109	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	18,825		8,109	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/12/2023 10:47 am

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	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	803,098	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,186,891	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	122,924	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,028,013	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,066,962	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,889,816	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,627	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,915,667	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	394,989	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	37,418,987		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/12/2023 10:47 am

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	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	247,686	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	490,410	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	49,803	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,948,901	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,624,068	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,380,628	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	801	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,999,522	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	114,454	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		15,856,273	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Total (lines 50 through 199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

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)	18,825	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,825	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)	18,825	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)	8,109	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)	18,956,763	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)	18,956,763	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)	18,956,763	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)	1,007.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,165,763	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)	8,165,763	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

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)						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)	3,159,280	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)	11,325,043	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)	1,002,191	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	199,376	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,201,567	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,123,476	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
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

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	2,326,622	18,956,763	0.122733	0	0	90.00
91.00	Nursing Program cost	0	18,956,763	0.000000	0	0	91.00
92.00	Allied health cost	0	18,956,763	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,956,763	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,825	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,825	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)	18,825	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)	108	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)	18,954,805	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)	18,954,805	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)	18,954,805	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)	1,006.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	108,745	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)	108,745	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	0	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)	108,745	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
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
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/12/2023 10:47 am

Title XIX | Hospital | Cost

	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	2,326,622	18,954,805	0.122746	0	0	90.00
91.00	Nursing Program cost	0	18,954,805	0.000000	0	0	91.00
92.00	Allied health cost	0	18,954,805	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,954,805	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-2 | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered	0.00	0				1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	0.00	0	18,825	0.00	0	2.00
3.00	INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)	0.00	0				9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)	0.00	0				20.00

	Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V	
		1.00	2.00	3.00	4.00	5.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0.00	0	0	0.000000	0	23.00
24.00	EMERGENCY	0.00	0	0	0.000000	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)	0.00	0				27.00
28.00	Total (sum of lines 20 and 27)	0.00	0				28.00

	Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
	Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0	0	0.00	29.00
30.00	Swing Bed - SNF		0	0	0	0.00	30.00
31.00	Swing Bed - NF		0				31.00
32.00	INTENSIVE CARE UNIT	0		0	0	0.00	32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)	0		0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0		0	0	0.00	41.00
42.00	Total (sum of lines 37 through 41)	0		0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-2 | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	Not In Approved Teaching Program (from Part I:)	Not In Approved Teaching Program Amount	In Approved Teaching Program (from Part II, col. 7, -)	
		1.00	2.00	3.00	
	PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
	Hospital				
43.00	Inpatient	col. 9, line 9.00	0	line 37.00	43.00
44.00	Outpatient	col. 9, line 27.00	0		44.00
45.00	Total Hospital (sum of lines 43 and 44)		0		45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	col. 9, line 13.00	0	col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-2 | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	Health Care Program Inpatient Days: Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Health Care Program Inpatient Days: Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		6.00	7.00	8.00	9.00	10.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered						1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	8,109	108	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00

	Cost Center Description	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XIX	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title V	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XIX	
		6.00	7.00	8.00	9.00	10.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00

	Cost Center Description	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents	
		6.00	7.00	11.00	
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)				
	Hospital Inpatient Routine Services:				
29.00	ADULTS & PEDIATRICS		0		29.00
30.00	Swing Bed - SNF		0		30.00
31.00	Swing Bed - NF				31.00
32.00	INTENSIVE CARE UNIT		0		32.00
33.00	CORONARY CARE UNIT				33.00
34.00	BURN INTENSIVE CARE UNIT				34.00
35.00	SURGICAL INTENSIVE CARE UNIT				35.00
36.00	OTHER SPECIAL CARE (SPECIFY)				36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0		37.00
38.00	SUBPROVIDER - IPF				38.00
39.00	SUBPROVIDER - IRF				39.00
40.00	SUBPROVIDER				40.00
41.00	SKILLED NURSING FACILITY		0		41.00
42.00	Total (sum of lines 37 through 41)		0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-2 | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
		Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
		4.00	5.00	6.00		
	PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
	Hospital					
43.00	Inpatient	0		0		43.00
44.00	Outpatient					44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00	SUBPROVIDER - IPF					46.00
47.00	SUBPROVIDER - IRF					47.00
48.00	SUBPROVIDER					48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0		49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/12/2023 10:47 am

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		15,014,927		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607389	247,686	150,442	54.00
60.00	06000	LABORATORY	0.063602	490,410	31,191	60.00
65.00	06500	RESPIRATORY THERAPY	2.047542	49,803	101,974	65.00
66.00	06600	PHYSICAL THERAPY	0.223130	4,948,901	1,104,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.159677	5,624,068	898,034	67.00
68.00	06800	SPEECH PATHOLOGY	0.121611	2,380,628	289,511	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46.095606	801	36,923	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269330	1,999,522	538,531	73.00
74.00	07400	RENAL DIALYSIS	0.073620	114,454	8,426	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,856,273	3,159,280	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)		15,856,273		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/12/2023 10:47 am

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		16,993,690		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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)		16,993,690		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		8,005		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		17,001,695		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/12/2023 10:47 am
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	16,646,886	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0427	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	822,356	3.00
4.00	Outlier Payments	24,370	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)	51.575342	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)	17,493,612	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)	17,493,612	17.00
18.00	Primary payer payments	9,579	18.00
19.00	Subtotal (line 17 less line 18).	17,484,033	19.00
20.00	Deductibles	220,376	20.00
21.00	Subtotal (line 19 minus line 20)	17,263,657	21.00
22.00	Coinsurance	60,043	22.00
23.00	Subtotal (line 21 minus line 22)	17,203,614	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,133	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	15,036	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,160	26.00
27.00	Subtotal (sum of lines 23 and 25)	17,218,650	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)	0	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)	17,218,650	32.00
32.01	Sequestration adjustment (see instructions)	216,955	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	16,993,690	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)	8,005	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	24,370	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 BEFORE 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: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 5/12/2023 10:47 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	0	1.00
1.01	Full standard payment amount	0	1.01
1.02	Short stay outlier standard payment amount	0	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	0	1.04
2.00	Outlier Payments	0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	0	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	0	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	0	9.00
10.00	Deductibles	0	10.00
11.00	Subtotal (line 9 minus line 10)	0	11.00
12.00	Coinsurance	0	12.00
13.00	Subtotal (line 11 minus line 12)	0	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	0	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	16.00
17.00	Subtotal (sum of lines 13 and 15)	0	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	0	22.00
22.01	Sequestration adjustment (see instructions)	0	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	0	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	0	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	0	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 (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/12/2023 10:47 am
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	16,646,886	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0427	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	822,356	3.00
4.00	Outlier Payments	24,370	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)	51.575342	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)	17,493,612	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)	17,493,612	17.00
18.00	Primary payer payments	9,579	18.00
19.00	Subtotal (line 17 less line 18).	17,484,033	19.00
20.00	Deductibles	220,376	20.00
21.00	Subtotal (line 19 minus line 20)	17,263,657	21.00
22.00	Coinsurance	60,043	22.00
23.00	Subtotal (line 21 minus line 22)	17,203,614	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,133	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	15,036	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,160	26.00
27.00	Subtotal (sum of lines 23 and 25)	17,218,650	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)	0	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)	17,218,650	32.00
32.01	Sequestration adjustment (see instructions)	216,955	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	16,993,690	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)	8,005	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	24,370	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 BEFORE 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: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 5/12/2023 10:47 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	0	1.00
1.01	Full standard payment amount	0	1.01
1.02	Short stay outlier standard payment amount	0	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	0	1.04
2.00	Outlier Payments	0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	0	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	0	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	0	9.00
10.00	Deductibles	0	10.00
11.00	Subtotal (line 9 minus line 10)	0	11.00
12.00	Coinsurance	0	12.00
13.00	Subtotal (line 11 minus line 12)	0	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	0	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	16.00
17.00	Subtotal (sum of lines 13 and 15)	0	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	0	22.00
22.01	Sequestration adjustment (see instructions)	0	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	0	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	0	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	0	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 (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/12/2023 10:47 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	108,745		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	108,745	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	108,745	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	108,745	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	108,745	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS	0	0	37.00
37.01	OTHER ADJUSTMENTS	0	0	37.01
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/12/2023 10:47 am

		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	3,562,962	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,310,741	0	0	0	4.00
5.00	Other receivable	167	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-595,989	0	0	0	6.00
7.00	Inventory	128,903	0	0	0	7.00
8.00	Prepaid expenses	240,194	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,646,978	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	10,041	0	0	0	17.00
18.00	Accumulated depreciation	-7,614	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	649,218	0	0	0	23.00
24.00	Accumulated depreciation	-296,625	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)	355,020	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	27,390	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	16,364,960	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,392,350	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,394,348	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,539,498	0	0	0	37.00
38.00	Salaries, wages, and fees payable	738,746	0	0	0	38.00
39.00	Payroll taxes payable	157,744	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,795,323	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,231,311	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,187,470	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,187,470	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,418,781	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,975,567				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)	12,975,567	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,394,348	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/12/2023 10:47 am

		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		12,799,593		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,217,867				2.00
3.00	Total (sum of line 1 and line 2)		26,017,460		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,017,460		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	13,041,893		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)		13,041,893		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,975,567		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments)		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		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	Deductions (debit adjustments)		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/12/2023 10:47 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	35,233,339		35,233,339	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	35,233,339		35,233,339	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,233,339		35,233,339	17.00
18.00	Ancillary services	37,418,987	0	37,418,987	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,652,326	0	72,652,326	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,007,603		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)		26,007,603		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3043 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/12/2023 10:47 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,652,326	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,306,062	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,346,264	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,007,603	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,338,661	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	999	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	969	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	13,870	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	298	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,676	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	9,635	24.00
24.50	COVID-19 PHE Funding	-148,241	24.50
25.00	Total other income (sum of lines 6-24)	-120,794	25.00
26.00	Total (line 5 plus line 25)	13,217,867	26.00
27.00	OTHER EXPENSES	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)	13,217,867	29.00