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: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 6/12/2023 11:56 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/12/2023 Time: 11:56 am
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 DAVIESS COMMUNITY HOSPITAL (15-0061) 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				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	265,005	-30,761	0	688,696	1.00
2.00	SUBPROVIDER - IPF	0	19,508	0		117,854	2.00
3.00	SUBPROVIDER - IRF	0	34,334	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		14,323		0	10.00
10.01	RURAL HEALTH CLINIC II	0		10,470		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-25,282		0	10.02
10.04	RURAL HEALTH CLINIC V	0		0		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		10,267		0	10.05
200.00	TOTAL	0	318,847	-20,983	0	806,550	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 6/12/2023 11:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1314 E. WALNUT STREET	PO Box: 760			1.00
2.00	City: WASHINGTON	State: IN	Zip Code: 47501	County: DAVIESS	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	DAVIESS COMMUNITY HOSPITAL	150061	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	DCH - PSYCH	15S061	99915	4	01/01/2003	N	P	O	4.00
5.00	Subprovider - IRF	DCH - REHAB	15T061	99915	5	01/01/2000	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DAVIESS COMMUNITY HOSPITAL	15U061	99915		11/10/1999	N	P	N	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	HELPING HEART HOSPICE	151553	99915		07/11/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY HOSPITAL MC	158500	99915		12/17/2003	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	NORTH DAVIESS MEDICAL CENTER	153999	99915		12/17/2003	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	DCH HEALTH PAVILION	158501	99915		03/30/2004	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV									15.03
15.04	Hospital-Based Health Clinic - RHC V	GRAND AVENUE PEDIATRICS	158503	99915		01/27/2005	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)	8		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/12/2023 11:56 am

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	200	58	0	4	919	78	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	51	0	0	71		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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)	Y	Y	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)	Y	N	40.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/12/2023 11:56 am

		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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/12/2023 11:56 am

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

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

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

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

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

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 6/12/2023 11:56 am

		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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/12/2023 11:56 am

		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

		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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	213,202	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			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

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		1.00	2.00	
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)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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.			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
161.10	CORF		N	N	N	161.10

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 6/12/2023 11:56 am

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 6/12/2023 11:56 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/31/2023	Y	03/31/2022	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.	Y		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 6/12/2023 11:56 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?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NICHOLAS		EICHELMAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000		NICHOLAS.EICHELMAN@FORVIS.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 6/12/2023 11:56 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	37	13,505	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)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 6/12/2023 11:56 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)	760	112	2,427			1.00
2.00	HMO and other (see instructions)	467	981				2.00
3.00	HMO IPF Subprovider	136	43				3.00
4.00	HMO IRF Subprovider	72	122				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)	760	112	2,427			7.00
8.00	INTENSIVE CARE UNIT	267	22	646			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		66	815			13.00
14.00	Total (see instructions)	1,027	200	3,888	0.00	298.95	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,821	525	3,845	0.00	27.60	16.00
17.00	SUBPROVIDER - IRF	1,016	0	1,400	0.00	11.38	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	3,046	3	3,933	0.00	3.72	24.00
24.10	HOSPICE (non-distinct part)			8			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	1,076	1,157	5,970	0.00	7.14	26.00
26.01	RURAL HEALTH CLINIC II	1,135	529	4,273	0.00	6.77	26.01
26.02	RURAL HEALTH CLINIC III	1,711	5,353	18,266	0.00	16.07	26.02
26.04	RURAL HEALTH CLINIC V	0	3,415	6,050	0.00	7.51	26.04
26.05	RURAL HEALTH CLINIC VI	1,142	509	5,109	0.00	7.08	26.05
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	386.22	27.00
28.00	Observation Bed Days		353	1,597			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			68			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	78	161			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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 6/12/2023 11:56 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	358	274	1,117	1.00
2.00	HMO and other (see instructions)			152	0		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	358	274	1,117	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	159	37	232	16.00
17.00	SUBPROVIDER - IRF	0.00	0	81	3	98	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 6/12/2023 11:56 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	29,288,402	266,349	29,554,751	962,337.00	30.71	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		27,000	0	27,000	161.87	166.80	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		1,359,239	0	1,359,239	9,644.63	140.93	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,673,664	0	2,673,664	83,564.34	32.00	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)		7,307,365	113,667	7,421,032	246,323.00	30.13	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		968,761	0	968,761	7,259.00	133.46	11.00
12.00	Contract labor: Top level management and other management and administrative services		591,115	0	591,115	4,160.00	142.09	12.00
13.00	Contract labor: Physician-Part A - Administrative		30,000	0	30,000	31.25	960.00	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		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,652,144	0	3,652,144			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,484,819	0	1,484,819			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		3,015	0	3,015			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		156,596	0	156,596			23.00
24.00	Wage-related costs (RHC/FQHC)		516,840	0	516,840			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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 6/12/2023 11:56 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	195,069	0	195,069	5,991.00	32.56	26.00
27.00	Administrative & General	5.00	3,098,561	-17,177	3,081,384	102,552.00	30.05	27.00
28.00	Administrative & General under contract (see inst.)		218,930	0	218,930	964.00	227.11	28.00
29.00	Maintenance & Repairs	6.00	68,634	0	68,634	2,160.00	31.78	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	546,669	0	546,669	34,346.00	15.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	354,267	-251,610	102,657	22,893.00	4.48	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	168,722	168,722	9,776.00	17.26	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	648,501	0	648,501	19,060.00	34.02	38.00
39.00	Central Services and Supply	14.00	295,384	0	295,384	13,264.00	22.27	39.00
40.00	Pharmacy	15.00	510,230	0	510,230	15,866.00	32.16	40.00
41.00	Medical Records & Medical Records Library	16.00	539,159	0	539,159	23,779.00	22.67	41.00
42.00	Social Service	17.00	0	266,349	266,349	8,879.00	30.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 6/12/2023 11:56 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)		25,474,429	266,349	25,740,778	870,092.03	29.58	1.00
2.00	Excluded area salaries (see instructions)		7,307,365	113,667	7,421,032	246,323.00	30.13	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,167,064	152,682	18,319,746	623,769.03	29.37	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,589,876	0	1,589,876	11,450.25	138.85	4.00
5.00	Subtotal wage-related costs (see inst.)		3,655,159	0	3,655,159	0.00	19.95	5.00
6.00	Total (sum of lines 3 thru 5)		23,412,099	152,682	23,564,781	635,219.28	37.10	6.00
7.00	Total overhead cost (see instructions)		6,475,404	166,284	6,641,688	259,530.00	25.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV | Date/Time Prepared: 6/12/2023 11:56 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	515,068	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	11,915	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)	2,946,931	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	25,827	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)	28,576	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	130,427	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	2,132,998	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	21,672	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,813,414	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 6/12/2023 11:56 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	968,761	5,813,414	1.00
2.00	Hospital	968,761	5,813,414	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	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			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1402 GRAND AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			202 NORTH WEST STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ODON		IN	47562	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-3999

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-8
Date/Time Prepared:
6/12/2023 11:56 am

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1805 S. STATE RD. 57		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8501

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-8
Date/Time Prepared:
6/12/2023 11:56 am

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1400 GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8503

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-8
Date/Time Prepared:
6/12/2023 11:56 am

RHC V | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 6/12/2023 11:56 am

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			12546 E US HWY 50		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0061 Component CCN: 15-8506	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 6/12/2023 11:56 am

RHC VI | Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
6/12/2023 11:56 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,033	0	521	3,554	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	13	0	0	13	13.00
14.00	Total Hospice Days	3,046	0	521	3,567	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 6/12/2023 11:56 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)	0.386356	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,085,686	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	30,687,192	6.00
7.00	Medicaid cost (line 1 times line 6)	11,856,181	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)	10,770,495	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)	10,770,495	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)	123,089	68,306	191,395	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	47,556	68,306	115,862	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)	47,556	68,306	115,862	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?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,275,728	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	98,301	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	151,233	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,124,495	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,260,099	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,375,961	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,146,456	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 6/12/2023 11:56 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		2,367,554	2,367,554	172,181	2,539,735	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,476,147	1,476,147	4,314	1,480,461	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	195,069	5,901,944	6,097,013	-57,938	6,039,075	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,098,561	12,081,662	15,180,223	-1,145,465	14,034,758	5.00
6.00	00600	MAINTENANCE & REPAIRS	68,634	2,176,318	2,244,952	0	2,244,952	6.00
7.00	00700	OPERATION OF PLANT	0	898,446	898,446	0	898,446	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,966	125,966	0	125,966	8.00
9.00	00900	HOUSEKEEPING	546,669	107,443	654,112	0	654,112	9.00
10.00	01000	DIETARY	354,267	320,393	674,660	-479,161	195,499	10.00
11.00	01100	CAFETERIA	0	0	0	321,311	321,311	11.00
13.00	01300	NURSING ADMINISTRATION	648,501	55,407	703,908	0	703,908	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	295,384	149,255	444,639	0	444,639	14.00
15.00	01500	PHARMACY	510,230	208,903	719,133	0	719,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	539,159	103,896	643,055	0	643,055	16.00
17.00	01700	SOCIAL SERVICE	0	76	76	266,349	266,425	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,543,869	469,432	3,013,301	-88,079	2,925,222	30.00
31.00	03100	INTENSIVE CARE UNIT	749,438	334,269	1,083,707	-78,319	1,005,388	31.00
40.00	04000	SUBPROVIDER - IPF	1,813,629	247,774	2,061,403	-83,236	1,978,167	40.00
41.00	04100	SUBPROVIDER - IRF	720,029	230,313	950,342	6,757	957,099	41.00
43.00	04300	NURSERY	0	11,236	11,236	537,224	548,460	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,606,195	1,421,661	3,027,856	-46	3,027,810	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,375	0	117,375	359,134	476,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	739,865	328,089	1,067,954	0	1,067,954	54.00
56.00	05600	RADIOISOTOPE	182,964	545,110	728,074	0	728,074	56.00
60.00	06000	LABORATORY	920,592	1,685,048	2,605,640	0	2,605,640	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,606	9,606	0	9,606	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	524,651	167,156	691,807	0	691,807	65.00
66.00	06600	PHYSICAL THERAPY	1,087,359	65,234	1,152,593	0	1,152,593	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,145	2,266	398,411	0	398,411	67.00
68.00	06800	SPEECH PATHOLOGY	205,635	2,153	207,788	0	207,788	68.00
69.00	06900	ELECTROCARDIOLOGY	64,473	12,402	76,875	0	76,875	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,848,477	1,848,477	-272,005	1,576,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	272,005	272,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,054,800	3,054,800	0	3,054,800	73.00
76.00	03020	CARDIAC REHAB	103,384	3,459	106,843	0	106,843	76.00
76.01	03030	ADDICTION SERVICES	204,143	36,255	240,398	0	240,398	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	671,601	85,736	757,337	0	757,337	88.00
88.01	08801	RURAL HEALTH CLINIC II	567,520	70,395	637,915	0	637,915	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,232,206	215,981	1,448,187	0	1,448,187	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	939,011	141,737	1,080,748	0	1,080,748	88.04
88.05	08804	RURAL HEALTH CLINIC VI	545,922	56,250	602,172	0	602,172	88.05
90.00	09000	CLINIC	216,002	95,469	311,471	0	311,471	90.00
90.01	09001	ONCOLOGY	278,760	11,015	289,775	0	289,775	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,295,505	3,231,683	4,527,188	-21,170	4,506,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	531,948	379,433	911,381	-112,733	798,648	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,241,406	402,216	2,643,622	0	2,643,622	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		241,084	241,084	0	241,084	113.00
116.00	11600	HOSPICE	236,949	181,130	418,079	-80	417,999	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,993,050	41,560,279	68,553,329	-398,957	68,154,372	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	2,295,352	1,221,468	3,516,820	398,957	3,915,777	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	29,288,402	42,781,747	72,070,149	0	72,070,149	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 6/12/2023 11:56 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	0	2,539,735		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,480,461		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-117,429	5,921,646		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,015,542	9,019,216		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,244,952		6.00
7.00	00700	OPERATION OF PLANT	0	898,446		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,966		8.00
9.00	00900	HOUSEKEEPING	0	654,112		9.00
10.00	01000	DIETARY	0	195,499		10.00
11.00	01100	CAFETERIA	-142,190	179,121		11.00
13.00	01300	NURSING ADMINISTRATION	0	703,908		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-750	443,889		14.00
15.00	01500	PHARMACY	-1,800	717,333		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,299	632,756		16.00
17.00	01700	SOCIAL SERVICE	0	266,425		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-839,050	2,086,172		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,005,388		31.00
40.00	04000	SUBPROVIDER - IPF	-508,436	1,469,731		40.00
41.00	04100	SUBPROVIDER - IRF	-174,714	782,385		41.00
43.00	04300	NURSERY	0	548,460		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,115,294	1,912,516		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	476,509		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-110,750	957,204		54.00
56.00	05600	RADIOISOTOPE	-741	727,333		56.00
60.00	06000	LABORATORY	0	2,605,640		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,606		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-58,073	633,734		65.00
66.00	06600	PHYSICAL THERAPY	0	1,152,593		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	398,411		67.00
68.00	06800	SPEECH PATHOLOGY	0	207,788		68.00
69.00	06900	ELECTROCARDIOLOGY	-3,841	73,034		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,576,472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	272,005		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,054,800		73.00
76.00	03020	CARDIAC REHAB	0	106,843		76.00
76.01	03030	ADDICTION SERVICES	0	240,398		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	757,337		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	637,915		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,448,187		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08803	RURAL HEALTH CLINIC V	0	1,080,748		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	602,172		88.05
90.00	09000	CLINIC	-2,500	308,971		90.00
90.01	09001	ONCOLOGY	0	289,775		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	-7,784	4,498,234		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	-339,995	458,653		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,643,622		95.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-241,084	0		113.00
116.00	11600	HOSPICE	0	417,999		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,690,272	59,464,100		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	3,915,777		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,690,272	63,379,877		200.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 6/12/2023 11:56 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY				
1.00	CAFETERIA	11.00	168,722	152,589	1.00
2.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	82,888	74,962	2.00
	TOTALS		251,610	227,551	
	C - BILLING COSTS				
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	17,177	25,758	1.00
	TOTALS		17,177	25,758	
	D - OBSTETRICS				
1.00	NURSERY	43.00	467,946	69,278	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	312,822	46,312	2.00
	TOTALS		780,768	115,590	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	172,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,314	2.00
3.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	0	199,028	3.00
	TOTALS		0	375,523	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	272,005	1.00
	TOTALS		0	272,005	
	G - SOCIAL SERVICES RECLASS				
1.00	SOCIAL SERVICE	17.00	266,349	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	TOTALS		266,349	0	
	H - OTHER				
1.00	ADULTS & PEDIATRICS	30.00	61,209	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	61,209	0	2.00
3.00	SUBPROVIDER - IPF	40.00	6,801	0	3.00
4.00	SUBPROVIDER - IRF	41.00	6,801	0	4.00
	TOTALS		136,020	0	
	I - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	750,400	1.00
	TOTALS		0	750,400	
	J - BENEFIT RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,938	1.00
	TOTALS		0	57,938	
500.00	Grand Total: Increases		1,451,924	1,824,765	500.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 6/12/2023 11:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY						
1.00	DIETARY	10.00	251,610	227,551	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		251,610	227,551			
	C - BILLING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	17,177	25,758	0		1.00
	TOTALS		17,177	25,758			
	D - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	780,768	115,590	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		780,768	115,590			
	E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	375,523	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	375,523			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	272,005	0		1.00
	TOTALS		0	272,005			
	G - SOCIAL SERVICES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,545	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,330	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,508	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	90,037	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	44	0		5.00
6.00	OPERATING ROOM	50.00	0	46	0		6.00
7.00	EMERGENCY	91.00	0	21,170	0		7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	0	112,733	0		8.00
9.00	HOSPICE	116.00	0	80	0		9.00
10.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	0	856	0		10.00
	TOTALS		0	266,349			
	H - OTHER						
1.00	INTENSIVE CARE UNIT	31.00	136,020	0	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
	TOTALS		136,020	0			
	I - HOSPITALIST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	750,400	0		1.00
	TOTALS		0	750,400			
	J - BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	57,938	0		1.00
	TOTALS		0	57,938			
500.00	Grand Total: Decreases		1,185,575	2,091,114			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 6/12/2023 11:56 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	1,280,955	0	0	0	0	1.00
2.00	Land Improvements	687,865	0	0	0	0	2.00
3.00	Buildings and Fixtures	43,627,507	123,646	0	123,646	0	3.00
4.00	Building Improvements	39,119	0	0	0	0	4.00
5.00	Fixed Equipment	11,586,418	109,643	0	109,643	0	5.00
6.00	Movable Equipment	32,363,542	561,950	0	561,950	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	89,585,406	795,239	0	795,239	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	89,585,406	795,239	0	795,239	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,280,955	0	1.00
2.00	Land Improvements	687,865	0	2.00
3.00	Buildings and Fixtures	43,751,153	0	3.00
4.00	Building Improvements	39,119	0	4.00
5.00	Fixed Equipment	11,696,061	0	5.00
6.00	Movable Equipment	32,925,492	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	90,380,645	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	90,380,645	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 6/12/2023 11:56 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	2,144,044	0	223,510	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,076,798	321,712	0	0	77,637	2.00
3.00	Total (sum of lines 1-2)	3,220,842	321,712	223,510	0	77,637	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	2,367,554		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,476,147		2.00
3.00	Total (sum of lines 1-2)	0	3,843,701		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 6/12/2023 11:56 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	57,455,153	0	57,455,153	0.635702	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,925,492	0	32,925,492	0.364298	0	2.00
3.00	Total (sum of lines 1-2)	90,380,645	0	90,380,645	1.000000	0	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	0	0	0	2,144,044	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,076,798	321,712	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,220,842	321,712	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	223,510	172,181	0	0	2,539,735	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,314	77,637	0	1,480,461	2.00
3.00	Total (sum of lines 1-2)	223,510	176,495	77,637	0	4,020,196	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 6/12/2023 11:56 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)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-750	CENTRAL SERVICES & SUPPLY	14.00	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	-1,518	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-24,121	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,153,394			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-142,190	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,800	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,299	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	A	-3,733	ADMINISTRATIVE & GENERAL	5.00	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 6/12/2023 11:56 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSES	A	-299,253	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT EXPENSES	A	-297,442	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.01	NON-ALLOWABLE COSTS	A	-13,070	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.04	PHYSICIAN BENEFITS	A	-117,429	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.04
36.00	CPR CLASS INCOME	B	-7,784	EMERGENCY	91.00	0	36.00
36.01	MISC. INCOME	B	-5,305	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	INTEREST EXPENSE OFFSET	A	-241,084	INTEREST EXPENSE	113.00	0	36.02
38.00	LOBBYING EXPENSE	A	-8,131	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DEBT ISSUANCE COST AMORTIZATION	A	21,245	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-4,384,214	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,690,272				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 6/12/2023 11:56 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	30.00	ADULTS & PEDIATRICS	839,050	839,050	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	508,436	508,436	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	174,714	174,714	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	1,115,294	1,115,294	0	246,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	110,750	110,750	0	271,900	0	5.00
6.00	56.00	RADIOISOTOPE	741	741	0	271,900	0	6.00
7.00	65.00	RESPIRATORY THERAPY	58,073	58,073	0	260,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	3,841	3,841	0	211,500	0	8.00
9.00	90.00	CLINIC	2,500	2,500	0	211,500	0	9.00
10.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	339,995	339,995	0	211,500	0	10.00
200.00			3,153,394	3,153,394	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	839,050		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	508,436		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	174,714		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,115,294		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	110,750		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	741		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	58,073		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,841		8.00
9.00	90.00	CLINIC	0	0	0	2,500		9.00
10.00	93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	339,995		10.00
200.00			0	0	0	3,153,394		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 6/12/2023 11:56 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	2,539,735	2,539,735				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,480,461		1,480,461			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,921,646	6,210	1,990	5,929,846		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,019,216	139,223	168,889	622,364	9,949,692	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,244,952	68,045	4,354	13,862	2,331,213	6.00
7.00	00700	OPERATION OF PLANT	898,446	490,724	0	0	1,389,170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,966	5,282	0	0	131,248	8.00
9.00	00900	HOUSEKEEPING	654,112	17,486	3,011	110,412	785,021	9.00
10.00	01000	DIETARY	195,499	45,854	8,320	20,734	270,407	10.00
11.00	01100	CAFETERIA	179,121	16,796	0	34,077	229,994	11.00
13.00	01300	NURSING ADMINISTRATION	703,908	33,740	18,151	130,979	886,778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	443,889	50,728	5,435	59,659	559,711	14.00
15.00	01500	PHARMACY	717,333	20,529	6,503	103,052	847,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	632,756	111,953	1,758	108,895	855,362	16.00
17.00	01700	SOCIAL SERVICE	266,425	0	0	53,795	320,220	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,086,172	107,146	65,535	368,460	2,627,313	30.00
31.00	03100	INTENSIVE CARE UNIT	1,005,388	27,044	18,974	136,256	1,187,662	31.00
40.00	04000	SUBPROVIDER - IPF	1,469,731	111,320	21,530	367,676	1,970,257	40.00
41.00	04100	SUBPROVIDER - IRF	782,385	98,109	7,993	146,799	1,035,286	41.00
43.00	04300	NURSERY	548,460	10,768	0	94,512	653,740	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,912,516	153,350	220,188	324,406	2,610,460	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	476,509	111,478	0	86,888	674,875	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	957,204	137,606	130,976	149,432	1,375,218	54.00
56.00	05600	RADIOISOTOPE	727,333	12,872	16,735	36,954	793,894	56.00
60.00	06000	LABORATORY	2,605,640	38,524	23,571	185,934	2,853,669	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,606	2,251	0	0	11,857	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	633,734	29,600	57,991	105,965	827,290	65.00
66.00	06600	PHYSICAL THERAPY	1,152,593	76,291	199,920	219,616	1,648,420	66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411	16,253	43,014	80,010	537,688	67.00
68.00	06800	SPEECH PATHOLOGY	207,788	11,514	31,443	41,533	292,278	68.00
69.00	06900	ELECTROCARDIOLOGY	73,034	7,013	5,809	13,022	98,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,576,472	0	992	0	1,577,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	272,005	0	0	0	272,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,054,800	3,631	0	0	3,058,431	73.00
76.00	03020	CARDIAC REHAB	106,843	26,003	0	20,881	153,727	76.00
76.01	03030	ADDICTION SERVICES	240,398	0	0	41,231	281,629	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	757,337	55,026	958	135,645	948,966	88.00
88.01	08801	RURAL HEALTH CLINIC II	637,915	39,406	1,113	114,623	793,057	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,448,187	60,569	7,589	248,871	1,765,216	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,080,748	21,965	1,758	189,654	1,294,125	88.04
88.05	08804	RURAL HEALTH CLINIC VI	602,172	28,854	776	110,261	742,063	88.05
90.00	09000	CLINIC	308,971	42,517	1,766	43,626	396,880	90.00
90.01	09001	ONCOLOGY	289,775	43,603	0	56,302	389,680	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,498,234	72,954	54,016	261,656	4,886,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	458,653	65,987	227	107,439	632,306	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,643,622	0	206,072	452,701	3,302,395	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	417,999	6,617	0	47,857	472,473	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,464,100	2,424,841	1,337,357	5,446,039	58,722,295	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	3,915,777	114,894	143,104	483,807	4,657,582	194.00
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)	63,379,877	2,539,735	1,480,461	5,929,846	63,379,877	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	9,949,692					5.00
6.00	00600	MAINTENANCE & REPAIRS	434,116	2,765,329				6.00
7.00	00700	OPERATION OF PLANT	258,690	583,345	2,231,205			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,441	6,279	6,421	168,389		8.00
9.00	00900	HOUSEKEEPING	146,186	20,787	21,256	12,306	985,556	9.00
10.00	01000	DIETARY	50,355	54,508	55,738	1,154	24,929	10.00
11.00	01100	CAFETERIA	42,829	19,967	20,417	0	9,132	11.00
13.00	01300	NURSING ADMINISTRATION	165,135	40,108	41,013	0	18,344	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,229	60,303	61,664	0	27,580	14.00
15.00	01500	PHARMACY	157,805	24,404	24,954	0	11,161	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,285	133,084	136,086	0	60,866	16.00
17.00	01700	SOCIAL SERVICE	59,631	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	489,256	127,370	130,243	40,369	58,253	30.00
31.00	03100	INTENSIVE CARE UNIT	221,165	32,148	32,874	5,767	14,703	31.00
40.00	04000	SUBPROVIDER - IPF	366,899	132,331	135,316	0	60,522	40.00
41.00	04100	SUBPROVIDER - IRF	192,790	116,627	119,258	6,920	53,339	41.00
43.00	04300	NURSERY	121,739	12,800	13,089	0	5,854	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	486,117	182,295	186,405	18,454	83,373	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,675	132,519	135,509	0	60,608	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,092	163,578	167,269	4,261	74,813	54.00
56.00	05600	RADIOISOTOPE	147,838	15,301	15,646	0	6,998	56.00
60.00	06000	LABORATORY	531,407	45,795	46,829	0	20,945	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,208	2,676	2,736	0	1,224	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	154,057	35,187	35,981	1,154	16,093	65.00
66.00	06600	PHYSICAL THERAPY	306,967	90,690	92,736	15,461	41,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,128	19,321	19,757	3,294	8,837	67.00
68.00	06800	SPEECH PATHOLOGY	54,428	13,688	13,996	2,333	6,260	68.00
69.00	06900	ELECTROCARDIOLOGY	18,413	8,336	8,524	0	3,813	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	293,754	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,652	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	569,538	4,316	4,413	0	1,974	73.00
76.00	03020	CARDIAC REHAB	28,627	30,911	31,609	0	14,137	76.00
76.01	03030	ADDICTION SERVICES	52,445	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	176,715	65,413	66,888	7,515	29,917	88.00
88.01	08801	RURAL HEALTH CLINIC II	147,682	46,844	47,901	0	21,424	88.01
88.02	08802	RURAL HEALTH CLINIC III	328,717	72,001	73,625	0	32,930	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	240,991	26,111	26,700	488	11,942	88.04
88.05	08804	RURAL HEALTH CLINIC VI	138,186	34,300	35,073	0	15,687	88.05
90.00	09000	CLINIC	73,907	50,542	51,682	1,226	23,115	90.00
90.01	09001	ONCOLOGY	72,566	51,833	53,002	3,460	23,706	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	910,002	86,724	88,680	10,380	39,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	117,747	78,441	80,211	16,147	35,875	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	614,969	0	0	4,613	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	87,983	7,866	8,043	0	3,597	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,082,362	2,628,749	2,091,544	155,302	923,091	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	867,330	136,580	139,661	13,087	62,465	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,949,692	2,765,329	2,231,205	168,389	985,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	457,091					10.00
11.00	01100	CAFETERIA	0	322,339				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,661	1,159,039			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,332	0	818,819		14.00
15.00	01500	PHARMACY	0	6,386	0	1,058	1,073,185	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,558	0	13	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,569	0	19	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153,867	25,841	202,491	15,360	0	30.00
31.00	03100	INTENSIVE CARE UNIT	55,333	8,348	65,414	3,141	0	31.00
40.00	04000	SUBPROVIDER - IPF	183,296	23,072	180,793	3,802	0	40.00
41.00	04100	SUBPROVIDER - IRF	64,595	9,517	74,574	2,220	0	41.00
43.00	04300	NURSERY	0	5,733	44,925	2,727	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,561	121,933	21,459	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,621	44,049	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,116	87,103	11,028	0	54.00
56.00	05600	RADIOISOTOPE	0	1,906	14,936	5,147	0	56.00
60.00	06000	LABORATORY	0	16,069	125,921	259,926	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,528	0	13,310	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,009	0	557	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,862	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,013	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	736	0	1,881	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	450,265	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,073,185	73.00
76.00	03020	CARDIAC REHAB	0	1,147	8,989	525	0	76.00
76.01	03030	ADDICTION SERVICES	0	3,894	30,515	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,967	0	380	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,658	0	1,208	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	13,439	0	1,816	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	6,277	0	1,042	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	5,921	0	478	0	88.05
90.00	09000	CLINIC	0	2,796	0	1,354	0	90.00
90.01	09001	ONCOLOGY	0	3,891	0	1,353	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	16,980	133,055	7,552	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	4,993	0	86	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	33,678	0	8,195	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,106	24,341	1,100	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	457,091	291,185	1,159,039	817,002	1,073,185	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	31,154	0	1,817	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	457,091	322,339	1,159,039	818,819	1,073,185	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,354,254					16.00
17.00	01700	SOCIAL SERVICE	0	383,439				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,406	5,249	3,896,018	0	3,896,018	30.00
31.00	03100	INTENSIVE CARE UNIT	14,376	5,249	1,646,180	0	1,646,180	31.00
40.00	04000	SUBPROVIDER - IPF	47,353	133,954	3,237,595	0	3,237,595	40.00
41.00	04100	SUBPROVIDER - IRF	16,648	99	1,691,873	0	1,691,873	41.00
43.00	04300	NURSERY	7,203	0	867,810	0	867,810	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,326	99	3,810,482	0	3,810,482	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,926	0	1,185,782	0	1,185,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,070	0	2,328,548	0	2,328,548	54.00
56.00	05600	RADIOISOTOPE	41,204	0	1,042,870	0	1,042,870	56.00
60.00	06000	LABORATORY	179,841	0	4,080,402	0	4,080,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,140	0	25,841	0	25,841	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	42,321	0	1,131,921	0	1,131,921	65.00
66.00	06600	PHYSICAL THERAPY	37,102	0	2,247,419	0	2,247,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,639	0	712,526	0	712,526	67.00
68.00	06800	SPEECH PATHOLOGY	6,308	0	391,304	0	391,304	68.00
69.00	06900	ELECTROCARDIOLOGY	7,707	0	148,288	0	148,288	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,089	0	2,382,572	0	2,382,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,700	0	329,357	0	329,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,108	0	4,836,965	0	4,836,965	73.00
76.00	03020	CARDIAC REHAB	5,145	0	274,817	0	274,817	76.00
76.01	03030	ADDICTION SERVICES	0	0	368,483	0	368,483	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,061	0	1,310,822	0	1,310,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,364	0	1,070,138	0	1,070,138	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,307	0	2,312,051	0	2,312,051	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	11,506	0	1,619,182	0	1,619,182	88.04
88.05	08804	RURAL HEALTH CLINIC VI	4,482	0	976,190	0	976,190	88.05
90.00	09000	CLINIC	11,471	0	612,973	0	612,973	90.00
90.01	09001	ONCOLOGY	8,032	0	607,523	0	607,523	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	299,601	32,882	6,512,379	0	6,512,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	15,297	204,421	1,185,524	0	1,185,524	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	45,523	0	4,009,373	0	4,009,373	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,998	99	615,606	0	615,606	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,354,254	382,052	57,468,814	0	57,468,814	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,387	1,387	0	1,387	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	5,909,676	0	5,909,676	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,354,254	383,439	63,379,877	0	63,379,877	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 6/12/2023 11:56 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	6,210	1,990	8,200	8,200	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	139,223	168,889	308,112	872	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	68,045	4,354	72,399	19	6.00
7.00	00700	OPERATION OF PLANT	0	490,724	0	490,724	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,282	0	5,282	0	8.00
9.00	00900	HOUSEKEEPING	0	17,486	3,011	20,497	153	9.00
10.00	01000	DIETARY	0	45,854	8,320	54,174	29	10.00
11.00	01100	CAFETERIA	0	16,796	0	16,796	47	11.00
13.00	01300	NURSING ADMINISTRATION	0	33,740	18,151	51,891	181	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,728	5,435	56,163	82	14.00
15.00	01500	PHARMACY	0	20,529	6,503	27,032	142	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	111,953	1,758	113,711	150	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	74	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	107,146	65,535	172,681	509	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,044	18,974	46,018	188	31.00
40.00	04000	SUBPROVIDER - IPF	0	111,320	21,530	132,850	508	40.00
41.00	04100	SUBPROVIDER - IRF	0	98,109	7,993	106,102	203	41.00
43.00	04300	NURSERY	0	10,768	0	10,768	131	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	153,350	220,188	373,538	448	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	111,478	0	111,478	120	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137,606	130,976	268,582	206	54.00
56.00	05600	RADIOISOTOPE	0	12,872	16,735	29,607	51	56.00
60.00	06000	LABORATORY	0	38,524	23,571	62,095	257	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,251	0	2,251	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	29,600	57,991	87,591	146	65.00
66.00	06600	PHYSICAL THERAPY	0	76,291	199,920	276,211	303	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,253	43,014	59,267	111	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,514	31,443	42,957	57	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,013	5,809	12,822	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	992	992	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,631	0	3,631	0	73.00
76.00	03020	CARDIAC REHAB	0	26,003	0	26,003	29	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	57	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	55,026	958	55,984	187	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	39,406	1,113	40,519	158	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	60,569	7,589	68,158	344	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	21,965	1,758	23,723	262	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	28,854	776	29,630	152	88.05
90.00	09000	CLINIC	0	42,517	1,766	44,283	60	90.00
90.01	09001	ONCOLOGY	0	43,603	0	43,603	78	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	72,954	54,016	126,970	361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	65,987	227	66,214	148	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	206,072	206,072	625	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	6,617	0	6,617	66	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,424,841	1,337,357	3,762,198	7,532	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	114,894	143,104	257,998	668	194.00
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)	0	2,539,735	1,480,461	4,020,196	8,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	308,984					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,481	85,899				6.00
7.00	00700	OPERATION OF PLANT	8,034	18,120	516,878			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	759	195	1,487	7,723		8.00
9.00	00900	HOUSEKEEPING	4,540	646	4,924	564	31,324	9.00
10.00	01000	DIETARY	1,564	1,693	12,912	53	792	10.00
11.00	01100	CAFETERIA	1,330	620	4,730	0	290	11.00
13.00	01300	NURSING ADMINISTRATION	5,128	1,246	9,501	0	583	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	1,873	14,285	0	877	14.00
15.00	01500	PHARMACY	4,901	758	5,781	0	355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,947	4,134	31,526	0	1,935	16.00
17.00	01700	SOCIAL SERVICE	1,852	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,194	3,956	30,172	1,853	1,851	30.00
31.00	03100	INTENSIVE CARE UNIT	6,868	999	7,615	264	467	31.00
40.00	04000	SUBPROVIDER - IPF	11,394	4,111	31,347	0	1,924	40.00
41.00	04100	SUBPROVIDER - IRF	5,987	3,623	27,627	317	1,695	41.00
43.00	04300	NURSERY	3,781	398	3,032	0	186	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,096	5,663	43,183	846	2,650	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,903	4,116	31,392	0	1,926	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,953	5,081	38,749	195	2,378	54.00
56.00	05600	RADIOISOTOPE	4,591	475	3,625	0	222	56.00
60.00	06000	LABORATORY	16,503	1,423	10,848	0	666	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69	83	634	0	39	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,784	1,093	8,335	53	511	65.00
66.00	06600	PHYSICAL THERAPY	9,533	2,817	21,483	709	1,318	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,109	600	4,577	151	281	67.00
68.00	06800	SPEECH PATHOLOGY	1,690	425	3,242	107	199	68.00
69.00	06900	ELECTROCARDIOLOGY	572	259	1,975	0	121	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,122	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,573	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,687	134	1,022	0	63	73.00
76.00	03020	CARDIAC REHAB	889	960	7,322	0	449	76.00
76.01	03030	ADDICTION SERVICES	1,629	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,488	2,032	15,495	345	951	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,586	1,455	11,097	0	681	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,208	2,237	17,056	0	1,047	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	7,484	811	6,185	22	380	88.04
88.05	08804	RURAL HEALTH CLINIC VI	4,291	1,065	8,125	0	499	88.05
90.00	09000	CLINIC	2,295	1,570	11,973	56	735	90.00
90.01	09001	ONCOLOGY	2,254	1,610	12,278	159	753	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	28,256	2,694	20,544	476	1,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	3,657	2,437	18,582	741	1,140	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	19,098	0	0	212	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,732	244	1,863	0	114	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,049	81,656	484,524	7,123	29,339	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	26,935	4,243	32,354	600	1,985	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	308,984	85,899	516,878	7,723	31,324	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	71,217					10.00
11.00	01100	CAFETERIA	0	23,813				11.00
13.00	01300	NURSING ADMINISTRATION	0	566	69,096			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	394	0	76,911		14.00
15.00	01500	PHARMACY	0	472	0	99	39,540	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	706	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	264	0	2	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,973	1,909	12,071	1,443	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,621	617	3,900	295	0	31.00
40.00	04000	SUBPROVIDER - IPF	28,559	1,704	10,778	357	0	40.00
41.00	04100	SUBPROVIDER - IRF	10,064	703	4,446	209	0	41.00
43.00	04300	NURSERY	0	424	2,678	256	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,150	7,269	2,016	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	415	2,626	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	821	5,193	1,036	0	54.00
56.00	05600	RADIOISOTOPE	0	141	890	483	0	56.00
60.00	06000	LABORATORY	0	1,187	7,507	24,415	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	482	0	1,250	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,035	0	52	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	359	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	149	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	54	0	177	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42,293	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	39,540	73.00
76.00	03020	CARDIAC REHAB	0	85	536	49	0	76.00
76.01	03030	ADDICTION SERVICES	0	288	1,819	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	441	0	36	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	418	0	113	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	993	0	171	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	464	0	98	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	437	0	45	0	88.05
90.00	09000	CLINIC	0	207	0	127	0	90.00
90.01	09001	ONCOLOGY	0	287	0	127	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,254	7,932	709	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	369	0	8	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,487	0	770	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	229	1,451	103	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,217	21,511	69,096	76,740	39,540	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	2,302	0	171	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,217	23,813	69,096	76,911	39,540	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	157,110					16.00
17.00	01700	SOCIAL SERVICE	0	2,192				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,368	30	268,010	0	268,010	30.00
31.00	03100	INTENSIVE CARE UNIT	1,668	30	77,550	0	77,550	31.00
40.00	04000	SUBPROVIDER - IPF	5,495	766	229,793	0	229,793	40.00
41.00	04100	SUBPROVIDER - IRF	1,932	1	162,909	0	162,909	41.00
43.00	04300	NURSERY	836	0	22,490	0	22,490	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,785	1	461,645	0	461,645	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	804	0	156,780	0	156,780	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,662	0	350,856	0	350,856	54.00
56.00	05600	RADIOISOTOPE	4,781	0	44,866	0	44,866	56.00
60.00	06000	LABORATORY	20,868	0	145,769	0	145,769	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	596	0	3,672	0	3,672	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,911	0	109,156	0	109,156	65.00
66.00	06600	PHYSICAL THERAPY	4,305	0	317,766	0	317,766	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,163	0	70,618	0	70,618	67.00
68.00	06800	SPEECH PATHOLOGY	732	0	49,558	0	49,558	68.00
69.00	06900	ELECTROCARDIOLOGY	894	0	16,892	0	16,892	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,088	0	59,495	0	59,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	777	0	2,350	0	2,350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,517	0	76,594	0	76,594	73.00
76.00	03020	CARDIAC REHAB	597	0	36,919	0	36,919	76.00
76.01	03030	ADDICTION SERVICES	0	0	3,793	0	3,793	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,051	0	82,010	0	82,010	88.00
88.01	08801	RURAL HEALTH CLINIC II	738	0	59,765	0	59,765	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,820	0	103,034	0	103,034	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,335	0	40,764	0	40,764	88.04
88.05	08804	RURAL HEALTH CLINIC VI	520	0	44,764	0	44,764	88.05
90.00	09000	CLINIC	1,331	0	62,637	0	62,637	90.00
90.01	09001	ONCOLOGY	932	0	62,081	0	62,081	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	34,735	188	225,380	0	225,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1,775	1,167	96,238	0	96,238	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,282	0	234,546	0	234,546	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	812	1	14,232	0	14,232	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,110	2,184	3,692,932	0	3,692,932	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8	8	0	8	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	327,256	0	327,256	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	157,110	2,192	4,020,196	0	4,020,196	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	224,543					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,393,559				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	549	1,873	29,359,682			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,309	158,975	3,081,384	-9,949,692	53,430,185	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,016	4,098	68,634	0	2,331,213	6.00
7.00	00700	OPERATION OF PLANT	43,386	0	0	0	1,389,170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	0	0	0	131,248	8.00
9.00	00900	HOUSEKEEPING	1,546	2,834	546,669	0	785,021	9.00
10.00	01000	DIETARY	4,054	7,832	102,657	0	270,407	10.00
11.00	01100	CAFETERIA	1,485	0	168,722	0	229,994	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	17,086	648,501	0	886,778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	5,116	295,384	0	559,711	14.00
15.00	01500	PHARMACY	1,815	6,121	510,230	0	847,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	1,655	539,159	0	855,362	16.00
17.00	01700	SOCIAL SERVICE	0	0	266,349	0	320,220	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	61,688	1,824,310	0	2,627,313	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	17,860	674,627	0	1,187,662	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	20,266	1,820,430	0	1,970,257	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	7,524	726,830	0	1,035,286	41.00
43.00	04300	NURSERY	952	0	467,946	0	653,740	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	207,263	1,606,195	0	2,610,460	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	0	430,197	0	674,875	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	123,288	739,865	0	1,375,218	54.00
56.00	05600	RADIOISOTOPE	1,138	15,753	182,964	0	793,894	56.00
60.00	06000	LABORATORY	3,406	22,187	920,592	0	2,853,669	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	0	0	0	11,857	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	54,587	524,651	0	827,290	65.00
66.00	06600	PHYSICAL THERAPY	6,745	188,185	1,087,359	0	1,648,420	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	40,489	396,145	0	537,688	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	29,597	205,635	0	292,278	68.00
69.00	06900	ELECTROCARDIOLOGY	620	5,468	64,473	0	98,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	934	0	0	1,577,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	272,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	0	0	0	3,058,431	73.00
76.00	03020	CARDIAC REHAB	2,299	0	103,384	0	153,727	76.00
76.01	03030	ADDICTION SERVICES	0	0	204,143	0	281,629	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	902	671,601	0	948,966	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	1,048	567,520	0	793,057	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,355	7,144	1,232,206	0	1,765,216	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,942	1,655	939,011	0	1,294,125	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	730	545,922	0	742,063	88.05
90.00	09000	CLINIC	3,759	1,662	216,002	0	396,880	90.00
90.01	09001	ONCOLOGY	3,855	0	278,760	0	389,680	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,450	50,845	1,295,505	0	4,886,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,834	214	531,948	0	632,306	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	193,976	2,241,406	0	3,302,395	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	0	236,949	0	472,473	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,385	1,258,855	26,964,265	-9,949,692	48,772,603	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	10,158	134,704	2,395,417	0	4,657,582	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,539,735	1,480,461	5,929,846		9,949,692	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	11.310684	1.062360	0.201972		0.186219	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,200		308,984	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000279		0.005783	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	205,669					6.00
7.00	00700	OPERATION OF PLANT	43,386	162,283				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	467	347,408			8.00
9.00	00900	HOUSEKEEPING	1,546	1,546	25,389	160,270		9.00
10.00	01000	DIETARY	4,054	4,054	2,380	4,054	28,673	10.00
11.00	01100	CAFETERIA	1,485	1,485	0	1,485	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	2,983	0	2,983	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	4,485	0	4,485	0	14.00
15.00	01500	PHARMACY	1,815	1,815	0	1,815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	9,898	0	9,898	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	9,473	83,285	9,473	9,652	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	2,391	11,898	2,391	3,471	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	9,842	0	9,842	11,498	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	8,674	14,277	8,674	4,052	41.00
43.00	04300	NURSERY	952	952	0	952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	13,558	38,073	13,558	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	9,856	0	9,856	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	12,166	8,792	12,166	0	54.00
56.00	05600	RADIOISOTOPE	1,138	1,138	0	1,138	0	56.00
60.00	06000	LABORATORY	3,406	3,406	0	3,406	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	199	0	199	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	2,617	2,380	2,617	0	65.00
66.00	06600	PHYSICAL THERAPY	6,745	6,745	31,897	6,745	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	1,437	6,795	1,437	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	1,018	4,814	1,018	0	68.00
69.00	06900	ELECTROCARDIOLOGY	620	620	0	620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	321	0	321	0	73.00
76.00	03020	CARDIAC REHAB	2,299	2,299	0	2,299	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	4,865	15,505	4,865	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	3,484	0	3,484	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,355	5,355	0	5,355	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,942	1,942	1,007	1,942	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	2,551	0	2,551	0	88.05
90.00	09000	CLINIC	3,759	3,759	2,529	3,759	0	90.00
90.01	09001	ONCOLOGY	3,855	3,855	7,139	3,855	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,450	6,450	21,416	6,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,834	5,834	33,314	5,834	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	9,518	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	585	0	585	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	195,511	152,125	320,408	150,112	28,673	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	10,158	10,158	27,000	10,158	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,765,329	2,231,205	168,389	985,556	457,091	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.445531	13.748852	0.484701	6.149348	15.941513	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,899	516,878	7,723	31,324	71,217	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.417657	3.185041	0.022230	0.195445	2.483765	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	801,922					11.00
13.00	01300	NURSING ADMINISTRATION	19,060	367,978				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,264	0	3,361,229			14.00
15.00	01500	PHARMACY	15,886	0	4,344	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,779	0	54	0	162,173,591	16.00
17.00	01700	SOCIAL SERVICE	8,879	0	76	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,288	64,288	63,051	0	2,443,506	30.00
31.00	03100	INTENSIVE CARE UNIT	20,768	20,768	12,894	0	1,721,468	31.00
40.00	04000	SUBPROVIDER - IPF	57,399	57,399	15,606	0	5,670,358	40.00
41.00	04100	SUBPROVIDER - IRF	23,676	23,676	9,115	0	1,993,495	41.00
43.00	04300	NURSERY	14,263	14,263	11,193	0	862,496	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,712	38,712	88,090	0	10,097,761	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,985	13,985	0	0	829,369	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,654	27,654	45,270	0	21,323,196	54.00
56.00	05600	RADIOISOTOPE	4,742	4,742	21,130	0	4,934,035	56.00
60.00	06000	LABORATORY	39,978	39,978	1,066,990	0	21,535,269	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	615,540	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,240	0	54,636	0	5,067,725	65.00
66.00	06600	PHYSICAL THERAPY	34,851	0	2,287	0	4,442,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,096	0	0	0	2,231,942	67.00
68.00	06800	SPEECH PATHOLOGY	5,007	0	0	0	755,395	68.00
69.00	06900	ELECTROCARDIOLOGY	1,832	0	7,723	0	922,925	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,848,319	0	7,315,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	802,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	14,981,253	73.00
76.00	03020	CARDIAC REHAB	2,854	2,854	2,157	0	616,074	76.00
76.01	03030	ADDICTION SERVICES	9,688	9,688	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,844	0	1,559	0	1,085,067	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,077	0	4,959	0	762,016	88.01
88.02	08802	RURAL HEALTH CLINIC III	33,434	0	7,456	0	2,910,700	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	15,616	0	4,276	0	1,377,845	88.04
88.05	08804	RURAL HEALTH CLINIC VI	14,731	0	1,963	0	536,690	88.05
90.00	09000	CLINIC	6,957	0	5,557	0	1,373,583	90.00
90.01	09001	ONCOLOGY	9,681	0	5,555	0	961,800	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	42,243	42,243	31,000	0	35,882,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	12,421	0	354	0	1,831,753	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	83,784	0	33,640	0	5,451,158	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,728	7,728	4,516	0	837,980	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	724,417	367,978	3,353,770	100	162,173,591	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	77,505	0	7,459	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	322,339	1,159,039	818,819	1,073,185	1,354,254	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.401958	3.149751	0.243607	10,731.850000	0.008351	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	23,813	69,096	76,911	39,540	157,110	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.029695	0.187772	0.022882	395.400000	0.000969	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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	7,743		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	106		30.00
31.00	03100	INTENSIVE CARE UNIT	106		31.00
40.00	04000	SUBPROVIDER - IPF	2,705		40.00
41.00	04100	SUBPROVIDER - IRF	2		41.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
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
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	CARDIAC REHAB	0		76.00
76.01	03030	ADDICTION SERVICES	0		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		88.03
88.04	08803	RURAL HEALTH CLINIC V	0		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0		88.05
90.00	09000	CLINIC	0		90.00
90.01	09001	ONCOLOGY	0		90.01
90.02	09002	PAIN MANAGEMENT	0		90.02
91.00	09100	EMERGENCY	664		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	4,128		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
99.10	09910	CORF	0		99.10
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	2		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,715		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	383,439		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.520728		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,192		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/12/2023 11:56 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.283094		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 am

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		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	3,896,018		3,896,018	0	3,896,018	30.00
31.00	03100	INTENSIVE CARE UNIT	1,646,180		1,646,180	0	1,646,180	31.00
40.00	04000	SUBPROVIDER - IPF	3,237,595		3,237,595	0	3,237,595	40.00
41.00	04100	SUBPROVIDER - IRF	1,691,873		1,691,873	0	1,691,873	41.00
43.00	04300	NURSERY	867,810		867,810	0	867,810	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,810,482		3,810,482	0	3,810,482	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,782		1,185,782	0	1,185,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,328,548		2,328,548	0	2,328,548	54.00
56.00	05600	RADIOISOTOPE	1,042,870		1,042,870	0	1,042,870	56.00
60.00	06000	LABORATORY	4,080,402		4,080,402	0	4,080,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,841		25,841	0	25,841	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,131,921	0	1,131,921	0	1,131,921	65.00
66.00	06600	PHYSICAL THERAPY	2,247,419	0	2,247,419	0	2,247,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	712,526	0	712,526	0	712,526	67.00
68.00	06800	SPEECH PATHOLOGY	391,304	0	391,304	0	391,304	68.00
69.00	06900	ELECTROCARDIOLOGY	148,288		148,288	0	148,288	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,382,572		2,382,572	0	2,382,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,357		329,357	0	329,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,836,965		4,836,965	0	4,836,965	73.00
76.00	03020	CARDIAC REHAB	274,817		274,817	0	274,817	76.00
76.01	03030	ADDICTION SERVICES	368,483		368,483	0	368,483	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,310,822		1,310,822	0	1,310,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,070,138		1,070,138	0	1,070,138	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,312,051		2,312,051	0	2,312,051	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,619,182		1,619,182	0	1,619,182	88.04
88.05	08804	RURAL HEALTH CLINIC VI	976,190		976,190	0	976,190	88.05
90.00	09000	CLINIC	612,973		612,973	0	612,973	90.00
90.01	09001	ONCOLOGY	607,523		607,523	0	607,523	90.01
90.02	09002	PAIN MANAGEMENT	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,512,379		6,512,379	0	6,512,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,546,215		1,546,215		1,546,215	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1,185,524		1,185,524	0	1,185,524	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,009,373		4,009,373	0	4,009,373	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	615,606		615,606		615,606	116.00
200.00		Subtotal (see instructions)	59,015,029	0	59,015,029	0	59,015,029	200.00
201.00		Less Observation Beds	1,546,215		1,546,215		1,546,215	201.00
202.00		Total (see instructions)	57,468,814	0	57,468,814	0	57,468,814	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,443,506		2,443,506			30.00
31.00	03100	INTENSIVE CARE UNIT	1,721,468		1,721,468			31.00
40.00	04000	SUBPROVIDER - IPF	5,670,358		5,670,358			40.00
41.00	04100	SUBPROVIDER - IRF	1,993,495		1,993,495			41.00
43.00	04300	NURSERY	862,496		862,496			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,624,273	8,808,430	10,432,703	0.365244	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	766,563	62,806	829,369	1.429740	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,559,223	18,763,973	21,323,196	0.109203	0.000000	54.00
56.00	05600	RADIOISOTOPE	426,755	4,507,280	4,934,035	0.211363	0.000000	56.00
60.00	06000	LABORATORY	4,848,977	16,686,292	21,535,269	0.189475	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	317,223	298,317	615,540	0.041981	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,002,244	2,065,481	5,067,725	0.223359	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	781,740	3,661,037	4,442,777	0.505859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	694,510	1,537,432	2,231,942	0.319240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	200,965	554,430	755,395	0.518012	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	205,424	717,501	922,925	0.160672	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,192,048	5,123,154	7,315,202	0.325701	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,748	685,519	802,267	0.410533	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,715,882	11,265,371	14,981,253	0.322868	0.000000	73.00
76.00	03020	CARDIAC REHAB	347	615,727	616,074	0.446078	0.000000	76.00
76.01	03030	ADDICTION SERVICES	3,195	51,871	55,066	6.691661	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,085,067	1,085,067			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	762,016	762,016			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,910,700	2,910,700			88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0			88.03
88.04	08803	RURAL HEALTH CLINIC V	151	1,275,771	1,275,922			88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	865,397	865,397			88.05
90.00	09000	CLINIC	0	957,605	957,605	0.640110	0.000000	90.00
90.01	09001	ONCOLOGY	3,230	1,045,841	1,049,071	0.579106	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	2,082,616	17,215,734	19,298,350	0.337458	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	362,883	3,596,986	3,959,869	0.390471	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,265	753,858	759,123	1.561702	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,451,158	5,451,158	0.735508	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	819,280	819,280			116.00
200.00		Subtotal (see instructions)	36,601,585	112,144,034	148,745,619			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,601,585	112,144,034	148,745,619			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.365244		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203		54.00
56.00	05600	RADIOISOTOPE	0.211363		56.00
60.00	06000	LABORATORY	0.189475		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.223359		65.00
66.00	06600	PHYSICAL THERAPY	0.505859		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240		67.00
68.00	06800	SPEECH PATHOLOGY	0.518012		68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868		73.00
76.00	03020	CARDIAC REHAB	0.446078		76.00
76.01	03030	ADDICTION SERVICES	6.691661		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08805	RURAL HEALTH CLINIC IV			88.03
88.04	08803	RURAL HEALTH CLINIC V			88.04
88.05	08804	RURAL HEALTH CLINIC VI			88.05
90.00	09000	CLINIC	0.640110		90.00
90.01	09001	ONCOLOGY	0.579106		90.01
90.02	09002	PAIN MANAGEMENT	0.000000		90.02
91.00	09100	EMERGENCY	0.337458		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.735508		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 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	3,896,018		3,896,018	0	3,896,018	30.00
31.00	03100	INTENSIVE CARE UNIT	1,646,180		1,646,180	0	1,646,180	31.00
40.00	04000	SUBPROVIDER - IPF	3,237,595		3,237,595	0	3,237,595	40.00
41.00	04100	SUBPROVIDER - IRF	1,691,873		1,691,873	0	1,691,873	41.00
43.00	04300	NURSERY	867,810		867,810	0	867,810	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,810,482		3,810,482	0	3,810,482	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,782		1,185,782	0	1,185,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,328,548		2,328,548	0	2,328,548	54.00
56.00	05600	RADIOISOTOPE	1,042,870		1,042,870	0	1,042,870	56.00
60.00	06000	LABORATORY	4,080,402		4,080,402	0	4,080,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,841		25,841	0	25,841	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,131,921	0	1,131,921	0	1,131,921	65.00
66.00	06600	PHYSICAL THERAPY	2,247,419	0	2,247,419	0	2,247,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	712,526	0	712,526	0	712,526	67.00
68.00	06800	SPEECH PATHOLOGY	391,304	0	391,304	0	391,304	68.00
69.00	06900	ELECTROCARDIOLOGY	148,288		148,288	0	148,288	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,382,572		2,382,572	0	2,382,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,357		329,357	0	329,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,836,965		4,836,965	0	4,836,965	73.00
76.00	03020	CARDIAC REHAB	274,817		274,817	0	274,817	76.00
76.01	03030	ADDICTION SERVICES	368,483		368,483	0	368,483	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,310,822		1,310,822	0	1,310,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,070,138		1,070,138	0	1,070,138	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,312,051		2,312,051	0	2,312,051	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1,619,182		1,619,182	0	1,619,182	88.04
88.05	08804	RURAL HEALTH CLINIC VI	976,190		976,190	0	976,190	88.05
90.00	09000	CLINIC	612,973		612,973	0	612,973	90.00
90.01	09001	ONCOLOGY	607,523		607,523	0	607,523	90.01
90.02	09002	PAIN MANAGEMENT	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,512,379		6,512,379	0	6,512,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,546,215		1,546,215		1,546,215	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1,185,524		1,185,524	0	1,185,524	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,009,373		4,009,373	0	4,009,373	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	615,606		615,606		615,606	116.00
200.00		Subtotal (see instructions)	59,015,029	0	59,015,029	0	59,015,029	200.00
201.00		Less Observation Beds	1,546,215		1,546,215		1,546,215	201.00
202.00		Total (see instructions)	57,468,814	0	57,468,814	0	57,468,814	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 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	2,443,506		2,443,506			30.00
31.00	03100	INTENSIVE CARE UNIT	1,721,468		1,721,468			31.00
40.00	04000	SUBPROVIDER - IPF	5,670,358		5,670,358			40.00
41.00	04100	SUBPROVIDER - IRF	1,993,495		1,993,495			41.00
43.00	04300	NURSERY	862,496		862,496			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,624,273	8,808,430	10,432,703	0.365244	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	766,563	62,806	829,369	1.429740	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,559,223	18,763,973	21,323,196	0.109203	0.000000	54.00
56.00	05600	RADIOISOTOPE	426,755	4,507,280	4,934,035	0.211363	0.000000	56.00
60.00	06000	LABORATORY	4,848,977	16,686,292	21,535,269	0.189475	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	317,223	298,317	615,540	0.041981	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,002,244	2,065,481	5,067,725	0.223359	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	781,740	3,661,037	4,442,777	0.505859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	694,510	1,537,432	2,231,942	0.319240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	200,965	554,430	755,395	0.518012	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	205,424	717,501	922,925	0.160672	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,192,048	5,123,154	7,315,202	0.325701	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,748	685,519	802,267	0.410533	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,715,882	11,265,371	14,981,253	0.322868	0.000000	73.00
76.00	03020	CARDIAC REHAB	347	615,727	616,074	0.446078	0.000000	76.00
76.01	03030	ADDICTION SERVICES	3,195	51,871	55,066	6.691661	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,085,067	1,085,067	1.208056	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	762,016	762,016	1.404351	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,910,700	2,910,700	0.794328	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0.000000	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	151	1,275,771	1,275,922	1.269029	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	865,397	865,397	1.128026	0.000000	88.05
90.00	09000	CLINIC	0	957,605	957,605	0.640110	0.000000	90.00
90.01	09001	ONCOLOGY	3,230	1,045,841	1,049,071	0.579106	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	2,082,616	17,215,734	19,298,350	0.337458	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	362,883	3,596,986	3,959,869	0.390471	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	5,265	753,858	759,123	1.561702	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,451,158	5,451,158	0.735508	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	819,280	819,280			116.00
200.00		Subtotal (see instructions)	36,601,585	112,144,034	148,745,619			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,601,585	112,144,034	148,745,619			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 6/12/2023 11:56 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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03030	ADDICTION SERVICES	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY	0.000000		90.01
90.02	09002	PAIN MANAGEMENT	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 6/12/2023 11:56 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	268,010	0	268,010	4,024	66.60	30.00
31.00	INTENSIVE CARE UNIT	77,550		77,550	646	120.05	31.00
40.00	SUBPROVIDER - IPF	229,793	0	229,793	3,845	59.76	40.00
41.00	SUBPROVIDER - IRF	162,909	0	162,909	1,400	116.36	41.00
43.00	NURSERY	22,490		22,490	815	27.60	43.00
200.00	Total (lines 30 through 199)	760,752		760,752	10,730		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	760	50,616	30.00
31.00	INTENSIVE CARE UNIT	267	32,053	31.00
40.00	SUBPROVIDER - IPF	2,821	168,583	40.00
41.00	SUBPROVIDER - IRF	1,016	118,222	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	4,864	369,474	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 6/12/2023 11:56 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	461,645	10,432,703	0.044250	358,917	15,882	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,780	829,369	0.189035	4,240	802	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,856	21,323,196	0.016454	1,154,519	18,996	54.00
56.00	05600	RADIOISOTOPE	44,866	4,934,035	0.009093	194,955	1,773	56.00
60.00	06000	LABORATORY	145,769	21,535,269	0.006769	1,616,711	10,944	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,672	615,540	0.005965	90,640	541	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	109,156	5,067,725	0.021539	822,009	17,705	65.00
66.00	06600	PHYSICAL THERAPY	317,766	4,442,777	0.071524	91,752	6,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,618	2,231,942	0.031640	36,270	1,148	67.00
68.00	06800	SPEECH PATHOLOGY	49,558	755,395	0.065605	18,546	1,217	68.00
69.00	06900	ELECTROCARDIOLOGY	16,892	922,925	0.018303	79,088	1,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,495	7,315,202	0.008133	525,139	4,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,350	802,267	0.002929	89,716	263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,594	14,981,253	0.005113	815,512	4,170	73.00
76.00	03020	CARDIAC REHAB	36,919	616,074	0.059926	326	20	76.00
76.01	03030	ADDICTION SERVICES	3,793	55,066	0.068881	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,010	1,085,067	0.075581	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	59,765	762,016	0.078430	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	103,034	2,910,700	0.035398	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	40,764	1,275,922	0.031949	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	44,764	865,397	0.051727	0	0	88.05
90.00	09000	CLINIC	62,637	957,605	0.065410	0	0	90.00
90.01	09001	ONCOLOGY	62,081	1,049,071	0.059177	2,659	157	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	225,380	19,298,350	0.011679	871,830	10,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	106,366	3,959,869	0.026861	171,357	4,603	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	96,238	759,123	0.126775	122	15	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,789,768	129,783,858		6,944,308	100,699	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 6/12/2023 11:56 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	4,024	0.00	760	30.00
31.00	03100	INTENSIVE CARE UNIT		0	646	0.00	267	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,845	0.00	2,821	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,400	0.00	1,016	41.00
43.00	04300	NURSERY		0	815	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	10,730		4,864	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 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	10,432,703	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	829,369	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,323,196	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,934,035	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	21,535,269	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	615,540	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,067,725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,442,777	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,231,942	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,395	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	922,925	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,315,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	802,267	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,981,253	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	616,074	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	55,066	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,085,067	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	762,016	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,910,700	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,275,922	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	865,397	0.000000	88.05
90.00	09000	CLINIC	0	0	0	957,605	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,049,071	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,298,350	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,959,869	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	759,123	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	129,783,858		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 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	358,917	0	1,521,743	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,240	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,154,519	0	3,974,926	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	194,955	0	1,400,010	0	56.00
60.00	06000	LABORATORY	0.000000	1,616,711	0	1,751,083	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	90,640	0	124,297	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	822,009	0	517,595	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	91,752	0	14,147	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	36,270	0	170	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,546	0	5,064	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	79,088	0	194,823	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	525,139	0	1,001,902	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	89,716	0	209,780	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	815,512	0	5,080,254	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	326	0	346,212	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	385,101	0	90.00
90.01	09001	ONCOLOGY	0.000000	2,659	0	154,932	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	871,830	0	2,765,598	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	171,357	0	1,200,679	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	122	0	313,382	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,944,308	0	20,961,698	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.365244	1,521,743	0	0	555,808	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	3,974,926	0	0	434,074	54.00
56.00	05600	RADIOISOTOPE	0.211363	1,400,010	0	0	295,910	56.00
60.00	06000	LABORATORY	0.189475	1,751,083	0	0	331,786	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	124,297	0	0	5,218	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	517,595	0	0	115,610	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	14,147	0	0	7,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	170	0	0	54	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	5,064	0	0	2,623	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	194,823	0	0	31,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	1,001,902	0	0	326,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	209,780	0	0	86,122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	5,080,254	0	5,030	1,640,251	73.00
76.00	03020	CARDIAC REHAB	0.446078	346,212	0	0	154,438	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08805	RURAL HEALTH CLINIC IV						88.03
88.04	08803	RURAL HEALTH CLINIC V						88.04
88.05	08804	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.640110	385,101	0	0	246,507	90.00
90.01	09001	ONCOLOGY	0.579106	154,932	0	0	89,722	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.337458	2,765,598	0	378	933,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	1,200,679	0	0	468,830	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	313,382	0	0	489,409	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.735508		0			95.00
200.00		Subtotal (see instructions)		20,961,698	0	5,408	6,214,414	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		20,961,698	0	5,408	6,214,414	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,624		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.01	03030	ADDICTION SERVICES	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08805	RURAL HEALTH CLINIC IV				88.03
88.04	08803	RURAL HEALTH CLINIC V				88.04
88.05	08804	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ONCOLOGY	0	0		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	0	128		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,752		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,752		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | 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	461,645	10,432,703	0.044250	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,780	829,369	0.189035	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,856	21,323,196	0.016454	194,579	3,202	54.00
56.00	05600	RADIOISOTOPE	44,866	4,934,035	0.009093	10,250	93	56.00
60.00	06000	LABORATORY	145,769	21,535,269	0.006769	620,092	4,197	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,672	615,540	0.005965	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	109,156	5,067,725	0.021539	283,804	6,113	65.00
66.00	06600	PHYSICAL THERAPY	317,766	4,442,777	0.071524	57,881	4,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,618	2,231,942	0.031640	5,571	176	67.00
68.00	06800	SPEECH PATHOLOGY	49,558	755,395	0.065605	18,363	1,205	68.00
69.00	06900	ELECTROCARDIOLOGY	16,892	922,925	0.018303	33,123	606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,495	7,315,202	0.008133	81,360	662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,350	802,267	0.002929	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,594	14,981,253	0.005113	907,509	4,640	73.00
76.00	03020	CARDIAC REHAB	36,919	616,074	0.059926	0	0	76.00
76.01	03030	ADDICTION SERVICES	3,793	55,066	0.068881	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,010	1,085,067	0.075581	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	59,765	762,016	0.078430	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	103,034	2,910,700	0.035398	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	40,764	1,275,922	0.031949	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	44,764	865,397	0.051727	0	0	88.05
90.00	09000	CLINIC	62,637	957,605	0.065410	0	0	90.00
90.01	09001	ONCOLOGY	62,081	1,049,071	0.059177	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	225,380	19,298,350	0.011679	240,406	2,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,959,869	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	96,238	759,123	0.126775	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,683,402	129,783,858		2,452,938	27,842	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | 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	10,432,703	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	829,369	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,323,196	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,934,035	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	21,535,269	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	615,540	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,067,725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,442,777	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,231,942	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,395	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	922,925	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,315,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	802,267	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,981,253	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	616,074	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	55,066	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,085,067	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	762,016	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,910,700	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,275,922	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	865,397	0.000000	88.05
90.00	09000	CLINIC	0	0	0	957,605	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,049,071	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,298,350	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,959,869	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	759,123	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	129,783,858		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	194,579	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	10,250	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	620,092	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	283,804	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	57,881	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,571	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,363	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	33,123	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	81,360	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	907,509	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	240,406	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,452,938	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	461,645	10,432,703	0.044250	29,272	1,295	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,780	829,369	0.189035	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,856	21,323,196	0.016454	80,644	1,327	54.00
56.00	05600	RADIOISOTOPE	44,866	4,934,035	0.009093	13,040	119	56.00
60.00	06000	LABORATORY	145,769	21,535,269	0.006769	184,704	1,250	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,672	615,540	0.005965	11,130	66	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	109,156	5,067,725	0.021539	362,170	7,801	65.00
66.00	06600	PHYSICAL THERAPY	317,766	4,442,777	0.071524	399,982	28,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,618	2,231,942	0.031640	462,806	14,643	67.00
68.00	06800	SPEECH PATHOLOGY	49,558	755,395	0.065605	59,771	3,921	68.00
69.00	06900	ELECTROCARDIOLOGY	16,892	922,925	0.018303	4,499	82	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,495	7,315,202	0.008133	127,287	1,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,350	802,267	0.002929	20,115	59	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,594	14,981,253	0.005113	190,178	972	73.00
76.00	03020	CARDIAC REHAB	36,919	616,074	0.059926	0	0	76.00
76.01	03030	ADDICTION SERVICES	3,793	55,066	0.068881	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,010	1,085,067	0.075581	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	59,765	762,016	0.078430	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	103,034	2,910,700	0.035398	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	40,764	1,275,922	0.031949	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	44,764	865,397	0.051727	0	0	88.05
90.00	09000	CLINIC	62,637	957,605	0.065410	0	0	90.00
90.01	09001	ONCOLOGY	62,081	1,049,071	0.059177	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	225,380	19,298,350	0.011679	59,189	691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,959,869	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	96,238	759,123	0.126775	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,683,402	129,783,858		2,004,787	61,869	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,432,703	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	829,369	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,323,196	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,934,035	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	21,535,269	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	615,540	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,067,725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,442,777	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,231,942	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,395	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	922,925	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,315,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	802,267	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,981,253	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	616,074	0.000000	76.00
76.01	03030	ADDICTION SERVICES	0	0	0	55,066	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,085,067	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	762,016	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,910,700	0.000000	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,275,922	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	865,397	0.000000	88.05
90.00	09000	CLINIC	0	0	0	957,605	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	1,049,071	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,298,350	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,959,869	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	759,123	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	129,783,858		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	29,272	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	80,644	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	13,040	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	184,704	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	11,130	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	362,170	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	399,982	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	462,806	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	59,771	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,499	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	127,287	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	20,115	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	190,178	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	ADDICTION SERVICES	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	59,189	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,004,787	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.365244	0	211,541	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	0	1,508	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	0	450,632	0	0	54.00
56.00	05600	RADIOISOTOPE	0.211363	0	108,246	0	0	56.00
60.00	06000	LABORATORY	0.189475	0	400,735	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	0	7,164	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	0	49,604	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	0	87,923	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	0	36,923	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	0	13,315	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	0	17,231	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	0	123,037	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	0	16,463	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	0	270,547	0	0	73.00
76.00	03020	CARDIAC REHAB	0.446078	0	14,788	0	0	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	1,245	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08805	RURAL HEALTH CLINIC IV						88.03
88.04	08803	RURAL HEALTH CLINIC V						88.04
88.05	08804	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.640110	0	22,998	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	0	25,117	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.337458	0	413,450	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	0	86,384	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	0	18,105	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.735508	0	0			95.00
200.00		Subtotal (see instructions)		0	2,376,956	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,376,956	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	77,264	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,156	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,210	0		54.00
56.00	05600	RADIOISOTOPE	22,879	0		56.00
60.00	06000	LABORATORY	75,929	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	301	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	11,079	0		65.00
66.00	06600	PHYSICAL THERAPY	44,477	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,787	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,897	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,769	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,073	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,759	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,351	0		73.00
76.00	03020	CARDIAC REHAB	6,597	0		76.00
76.01	03030	ADDICTION SERVICES	8,331	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08805	RURAL HEALTH CLINIC IV				88.03
88.04	08803	RURAL HEALTH CLINIC V				88.04
88.05	08804	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	14,721	0		90.00
90.01	09001	ONCOLOGY	14,545	0		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	139,522	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,730	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	28,275	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	684,652	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	684,652	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/12/2023 11:56 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)	4,024	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,024	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)	2,427	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)	760	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)	3,896,018	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)	3,896,018	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,896,018	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)	968.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	735,832	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)	735,832	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/12/2023 11:56 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,646,180	646	2,548.27	267	680,388	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,712,642	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)	3,128,862	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)	82,669	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	100,699	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	183,368	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,945,494	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)	1,597	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	968.20	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,546,215	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	268,010	3,896,018	0.068791	1,546,215	106,366	90.00
91.00	Nursing Program cost	0	3,896,018	0.000000	1,546,215	0	91.00
92.00	Allied health cost	0	3,896,018	0.000000	1,546,215	0	92.00
93.00	All other Medical Education	0	3,896,018	0.000000	1,546,215	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061	Period: From 01/01/2022	Worksheet D-1
Component CCN: 15-S061	To 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
Title XVIII	Subprovider - IPF	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)	3,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,845	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)	3,845	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,821	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)	3,237,595	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)	3,237,595	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,237,595	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)	842.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,375,367	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)	2,375,367	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1

Component CCN: 15-S061 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	650,821	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)	3,026,188	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)	168,583	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	27,842	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	196,425	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,829,763	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description		
		1.00	
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

	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	229,793	3,237,595	0.070976	0	0	90.00
91.00	Nursing Program cost	0	3,237,595	0.000000	0	0	91.00
92.00	Allied health cost	0	3,237,595	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,237,595	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,400	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)	1,400	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)	1,016	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)	1,691,873	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)	1,691,873	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)	1,691,873	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)	1,208.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,227,816	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,227,816	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1

Component CCN: 15-T061 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	651,469	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,879,285	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)	118,222	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	61,869	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	180,091	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,699,194	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description		
		1.00	
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

	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	162,909	1,691,873	0.096289	0	0	90.00
91.00	Nursing Program cost	0	1,691,873	0.000000	0	0	91.00
92.00	Allied health cost	0	1,691,873	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,691,873	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/12/2023 11:56 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)	4,024	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,024	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)	2,427	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)	112	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)	815	15.00
16.00	Nursery days (title V or XIX only)	66	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)	3,896,018	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)	3,896,018	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,896,018	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)	968.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	108,438	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)	108,438	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/12/2023 11:56 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)	867,810	815	1,064.80	66	70,277	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,646,180	646	2,548.27	22	56,062	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)	456,016	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)	690,793	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)	1,597	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	968.20	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,546,215	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	268,010	3,896,018	0.068791	1,546,215	106,366	90.00
91.00	Nursing Program cost	0	3,896,018	0.000000	1,546,215	0	91.00
92.00	Allied health cost	0	3,896,018	0.000000	1,546,215	0	92.00
93.00	All other Medical Education	0	3,896,018	0.000000	1,546,215	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IPF	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)	3,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,845	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)	3,845	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)	525	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)	815	15.00
16.00	Nursery days (title V or XIX only)	66	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)	3,237,595	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)	3,237,595	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,237,595	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)	842.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	442,066	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)	442,066	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1

Component CCN: 15-S061 | Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	31,593	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)	473,659	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description		
		1.00	
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

	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	229,793	3,237,595	0.070976	0	0	90.00
91.00	Nursing Program cost	0	3,237,595	0.000000	0	0	91.00
92.00	Allied health cost	0	3,237,595	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,237,595	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IRF	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)	1,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,400	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)	1,400	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)	0	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)	815	15.00
16.00	Nursery days (title V or XIX only)	66	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)	1,691,873	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)	1,691,873	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)	1,691,873	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)	1,208.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	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)	0	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description		
		1.00	
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

	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	162,909	1,691,873	0.096289	0	0	90.00
91.00	Nursing Program cost	0	1,691,873	0.000000	0	0	91.00
92.00	Allied health cost	0	1,691,873	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,691,873	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/12/2023 11:56 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		636,364		30.00
31.00	03100	INTENSIVE CARE UNIT		754,305		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.365244	358,917	131,092	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	4,240	6,062	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	1,154,519	126,077	54.00
56.00	05600	RADIOISOTOPE	0.211363	194,955	41,206	56.00
60.00	06000	LABORATORY	0.189475	1,616,711	306,326	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	90,640	3,805	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	822,009	183,603	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	91,752	46,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	36,270	11,579	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	18,546	9,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	79,088	12,707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	525,139	171,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	89,716	36,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	815,512	263,303	73.00
76.00	03020	CARDIAC REHAB	0.446078	326	145	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.640110	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	2,659	1,540	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.337458	871,830	294,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	171,357	66,910	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	122	191	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,944,308	1,712,642	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,944,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		4,715,603		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.365244	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	194,579	21,249	54.00
56.00	05600	RADIOISOTOPE	0.211363	10,250	2,166	56.00
60.00	06000	LABORATORY	0.189475	620,092	117,492	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	283,804	63,390	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	57,881	29,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	5,571	1,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	18,363	9,512	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	33,123	5,322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	81,360	26,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	907,509	293,006	73.00
76.00	03020	CARDIAC REHAB	0.446078	0	0	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.640110	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.337458	240,406	81,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,452,938	650,821	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)		2,452,938		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		1,516,918		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.365244	29,272	10,691	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	80,644	8,807	54.00
56.00	05600	RADIOISOTOPE	0.211363	13,040	2,756	56.00
60.00	06000	LABORATORY	0.189475	184,704	34,997	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	11,130	467	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	362,170	80,894	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	399,982	202,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	462,806	147,746	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	59,771	30,962	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	4,499	723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	127,287	41,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	20,115	8,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	190,178	61,402	73.00
76.00	03020	CARDIAC REHAB	0.446078	0	0	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.640110	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.337458	59,189	19,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,004,787	651,469	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)		2,004,787		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Hospital | Cost

		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		156,300		30.00
31.00	03100	INTENSIVE CARE UNIT		110,114		31.00
40.00	04000	SUBPROVIDER - IPF		366,691		40.00
41.00	04100	SUBPROVIDER - IRF		127,515		41.00
43.00	04300	NURSERY		55,170		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.365244	103,897	37,948	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	49,034	70,106	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	163,702	17,877	54.00
56.00	05600	RADIOISOTOPE	0.211363	27,298	5,770	56.00
60.00	06000	LABORATORY	0.189475	310,167	58,769	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	20,291	852	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	192,040	42,894	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	50,004	25,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	44,425	14,182	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	12,855	6,659	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	13,140	2,111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	140,215	45,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	6,917	2,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	237,688	76,742	73.00
76.00	03020	CARDIAC REHAB	0.446078	21	9	76.00
76.01	03030	ADDICTION SERVICES	6.691661	204	1,365	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.208056	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.404351	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.794328	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1.269029	-5,457	-6,925	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.128026	0	0	88.05
90.00	09000	CLINIC	0.640110	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	207	120	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.337458	133,215	44,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	23,212	9,064	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	-182	-284	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,522,893	456,016	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)		1,522,893		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/12/2023 11:56 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		248,344		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.365244	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.429740	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.109203	8,559	935	54.00
56.00	05600	RADIOISOTOPE	0.211363	402	85	56.00
60.00	06000	LABORATORY	0.189475	26,657	5,051	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.041981	115	5	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.223359	17,129	3,826	65.00
66.00	06600	PHYSICAL THERAPY	0.505859	2,516	1,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.319240	268	86	67.00
68.00	06800	SPEECH PATHOLOGY	0.518012	940	487	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160672	1,623	261	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325701	858	279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410533	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322868	41,843	13,510	73.00
76.00	03020	CARDIAC REHAB	0.446078	0	0	76.00
76.01	03030	ADDICTION SERVICES	6.691661	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.208056	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.404351	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.794328	0	0	88.02
88.03	08805	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
88.04	08803	RURAL HEALTH CLINIC V	1.269029	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.128026	0	0	88.05
90.00	09000	CLINIC	0.640110	0	0	90.00
90.01	09001	ONCOLOGY	0.579106	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.337458	16,881	5,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.390471	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	1.561702	63	98	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		117,854	31,593	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)		117,854		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,920,401	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	538,896	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	1,041,457	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	37.60	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)	30.58	31.00
32.00	Sum of lines 30 and 31	33.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		73,779	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000054055	0.000066664	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	388,762	458,274	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	290,773	115,510	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	406,283		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,939,359		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		2,939,359	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		181,302	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		33,574	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,154,235	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,154,235	61.00
62.00	Deductibles billed to program beneficiaries		382,128	62.00
63.00	Coinsurance billed to program beneficiaries		12,059	63.00
64.00	Allowable bad debts (see instructions)		41,939	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		27,260	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,850	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,787,308	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-606	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	451,882	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	170,783	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		27,889	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,381,478	71.00
71.01	Sequestration adjustment (see instructions)		42,607	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		3,073,866	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		265,005	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,920,401	0	1,920,401		1,920,401	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	538,896	0		538,896	538,896	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,041,457	0	622,945	418,512	1,041,457	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	73,779	0	57,612	16,167	73,779	11.00
11.01	Uncompensated care payments	36.00	406,283	0	290,773	115,510	406,283	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,939,359	0	2,268,786	670,573	2,939,359	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,939,359	0	2,268,786	670,573	2,939,359	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 6/12/2023 11:56 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	181,302	0	-39,520	220,822	181,302	16.00
17.00	Special add-on payments for new technologies	54.00	33,574	0	33,574	0	33,574	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,262,840	891,395	3,154,235	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	181,302	0	-39,520	220,822	181,302	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	181,302	0	-39,520	220,822	181,302	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.199697	0.191591		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			451,882		451,882	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				170,783	170,783	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 6/12/2023 11:56 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,920,401	1,920,401		1,920,401	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	538,896		538,896	538,896	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,041,457	622,945	418,512	1,041,457	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	73,779	57,612	16,167	73,779	11.00
11.01	Uncompensated care payments	36.00	406,283	290,774	115,510	406,284	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,939,359	2,268,786	670,573	2,939,359	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,939,359	2,268,786	670,573	2,939,359	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	181,302	-39,520	220,822	181,302	16.00
17.00	Special add-on payments for new technologies	54.00	33,574	33,574	0	33,574	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,262,840	891,395	3,154,235	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 6/12/2023 11:56 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	181,302	-39,520	220,822	181,302	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	181,302	-39,520	220,822	181,302	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	451,882	451,882		451,882	28.00
29.00	Low volume adjustment on or after October 1	70.97	170,783		170,783	170,783	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-606	-391	-215	-606	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		27,143	0	27,143	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,752	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,214,414	2.00
3.00	OPPS payments	4,640,500	3.00
4.00	Outlier payment (see instructions)	18,954	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,752	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,408	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	5,408	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	5,408	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,656	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,752	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,659,454	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	901,176	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,760,030	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,760,030	30.00
31.00	Primary payer payments	802	31.00
32.00	Subtotal (line 30 minus line 31)	3,759,228	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	80,016	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	52,010	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,378	36.00
37.00	Subtotal (see instructions)	3,811,238	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,811,238	40.00
40.01	Sequestration adjustment (see instructions)	48,022	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	3,793,977	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-30,761	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 6/12/2023 11:56 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		3,073,866		3,793,977	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)		3,073,866		3,793,977	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		265,005		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		30,761	6.02
7.00	Total Medicare program liability (see instructions)		3,338,871		3,763,216	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IPF | 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		2,856,817		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)		2,856,817		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		19,508		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,876,325		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,805,876		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)		1,805,876		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		34,334		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,840,210		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part II Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	3,114,771	1.00
2.00	Net IPF PPS Outlier Payments	7,456	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.534247	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3,122,227	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	3,122,227	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	3,122,227	18.00
19.00	Deductibles	155,096	19.00
20.00	Subtotal (line 18 minus line 19)	2,967,131	20.00
21.00	Coinsurance	73,132	21.00
22.00	Subtotal (line 20 minus line 21)	2,893,999	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,278	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	19,031	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,892	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,913,030	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,913,030	31.00
31.01	Sequestration adjustment (see instructions)	36,705	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,856,817	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	19,508	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	7,456	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: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,812,725	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	48,762	3.00
4.00	Outlier Payments	36,365	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)	3.835616	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)	1,897,852	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)	1,897,852	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,897,852	19.00
20.00	Deductibles	29,492	20.00
21.00	Subtotal (line 19 minus line 20)	1,868,360	21.00
22.00	Coinsurance	4,668	22.00
23.00	Subtotal (line 21 minus line 22)	1,863,692	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,863,692	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)	1,863,692	32.00
32.01	Sequestration adjustment (see instructions)	23,482	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	1,805,876	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)	34,334	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	36,365	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: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII | Date/Time Prepared: 6/12/2023 11:56 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	690,793		1.00
2.00	Medical and other services		684,652	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	690,793	684,652	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)	690,793	684,652	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,522,893	2,376,956	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)	1,522,893	2,376,956	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)	1,522,893	2,376,956	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	832,100	1,692,304	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	690,793	684,652	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)	690,793	684,652	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	690,793	684,652	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)	690,793	684,652	36.00
37.00	ZERO OUT MEDICAID	0	-686,749	37.00
38.00	Subtotal (line 36 ± line 37)	690,793	-2,097	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)	690,793	-2,097	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	690,793	-2,097	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IPF	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	473,659		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)	473,659	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)	473,659	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	117,854	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)	117,854	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)	117,854	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)	355,805	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)	117,854	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)	117,854	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	355,805	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	117,854	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)	117,854	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	117,854	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)	117,854	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	117,854	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovider - IRF	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	0		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)	0	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)	0	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)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	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)	0	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 (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 6/12/2023 11:56 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	19,254,908	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	19,209,226	0	0	0	4.00
5.00	Other receivable	910,012	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,107,683	0	0	0	6.00
7.00	Inventory	1,987,994	0	0	0	7.00
8.00	Prepaid expenses	447,653	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)	31,702,110	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,280,955	0	0	0	12.00
13.00	Land improvements	687,865	0	0	0	13.00
14.00	Accumulated depreciation	-686,530	0	0	0	14.00
15.00	Buildings	65,807,369	0	0	0	15.00
16.00	Accumulated depreciation	-49,321,930	0	0	0	16.00
17.00	Leasehold improvements	39,119	0	0	0	17.00
18.00	Accumulated depreciation	-37,162	0	0	0	18.00
19.00	Fixed equipment	11,899,728	0	0	0	19.00
20.00	Accumulated depreciation	-7,751,913	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	32,925,492	0	0	0	23.00
24.00	Accumulated depreciation	-29,480,324	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)	25,362,669	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,807,040	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,132,786	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,939,826	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,004,605	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,928,400	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-18	0	0	0	38.00
39.00	Payroll taxes payable	621,483	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,976,498	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	-636,003	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,890,360	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	10,316,431	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,316,431	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,206,791	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,797,814				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)	49,797,814	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,004,605	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 6/12/2023 11:56 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		44,610,942		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,394,806				2.00
3.00	Total (sum of line 1 and line 2)		36,216,136		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER TO LTC OPERATIONS	13,581,678		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)		13,581,678		0		10.00
11.00	Subtotal (line 3 plus line 10)		49,797,814		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,797,814		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/12/2023 11:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,292,138		7,292,138	1.00
2.00	SUBPROVIDER - IPF	7,385,231		7,385,231	2.00
3.00	SUBPROVIDER - IRF	2,259,918		2,259,918	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
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)	16,937,287		16,937,287	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,539,283		2,539,283	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)	2,539,283		2,539,283	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,476,570		19,476,570	17.00
18.00	Ancillary services	24,871,804	112,506,007	137,377,811	18.00
19.00	Outpatient services	0	1,651,360	1,651,360	19.00
20.00	RURAL HEALTH CLINIC	0	1,085,067	1,085,067	20.00
20.01	RURAL HEALTH CLINIC II	0	762,016	762,016	20.01
20.02	RURAL HEALTH CLINIC III	0	2,910,700	2,910,700	20.02
20.03	RURAL HEALTH CLINIC IV	0	0	0	20.03
20.04	RURAL HEALTH CLINIC V	0	1,230,689	1,230,689	20.04
20.05	RURAL HEALTH CLINIC VI	0	865,397	865,397	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	819,280	819,280	26.00
27.00	OTHER (SPECIFY)	0	5,306,514	5,306,514	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	44,348,374	127,137,030	171,485,404	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		72,070,149		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)		72,070,149		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 6/12/2023 11:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	171,485,404	1.00
2.00	Less contractual allowances and discounts on patients' accounts	110,111,350	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,374,054	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,070,149	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,696,095	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-330	6.00
7.00	Income from investments	136,070	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	750	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	142,190	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	266,574	17.00
18.00	Revenue from sale of medical records and abstracts	10,299	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	144,726	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - INCLUDES EHR REVENUE	904,744	24.00
24.50	COVID-19 PHE Funding	696,266	24.50
25.00	Total other income (sum of lines 6-24)	2,301,289	25.00
26.00	Total (line 5 plus line 25)	-8,394,806	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,394,806	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O | Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	87,687	19,705	107,392	0	107,392	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	4,267	4,267	0	4,267	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	270	270	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	40,596	40,596	0	40,596	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	98,191	116,292	214,483	0	214,483	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	50,991	0	50,991	0	50,991	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	80	0	80	0	80	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	236,949	181,130	418,079	0	418,079	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O | Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	107,392		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	4,267		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	270		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	40,596		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	214,483		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	-80	50,911		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	80		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-80	417,999		100.00

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

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

Provider CCN: 15-0061 Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-2 Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	40,443	40,443	0	40,443	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	97,821	115,854	213,675	0	213,675	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	50,799	0	50,799	0	50,799	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	80	0	80	0	80	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	148,700	156,297	304,997	0	304,997	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	40,443		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	213,675		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	-80	50,719		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	80		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	-80	304,917		100.00

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

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

Provider CCN: 15-0061 Hospice CCN: 15-1553 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-4 | Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	153	153	0	153	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	370	438	808	0	808	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	192	0	192	0	192	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	562	591	1,153	0	1,153	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	153		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	808		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	192		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,153		100.00

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

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

Provider CCN: 15-0061 Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-5

Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	6,617	6,617	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	47,857	47,857	3.00
4.00	ADMINISTRATIVE & GENERAL	107,392	91,089	198,481	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	15,909	15,909	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	3,597	3,597	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	24,341	24,341	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,100	1,100	10.00
11.00	MEDICAL RECORDS	0	6,998	6,998	11.00
12.00	STAFF TRANSPORTATION	4,267		4,267	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	270	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		99	99	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	304,917		304,917	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,153		1,153	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	417,999	197,607	615,606	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-6 Part I
Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,617	6,617				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	47,857	0	0	47,857		3.00
4.00	ADMINISTRATIVE & GENERAL	198,481	0	0	17,710	216,191	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,909	0	0	0	15,909	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	3,597	0	0	0	3,597	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	24,341	0	0	0	24,341	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,100	0	0	0	1,100	10.00
11.00	MEDICAL RECORDS	6,998	0	0	0	6,998	11.00
12.00	STAFF TRANSPORTATION	4,267	0	0	0	4,267	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	270	0	0	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		99	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	304,917			30,033	334,950	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,153	0	0	114	1,267	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	6,617	0	0	6,617	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	615,606	6,617	0	47,857	615,606	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-6 Part I Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	216,191					4.00
5.00	PLANT OPERATION & MAINTENANCE	8,611	24,520				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	1,947	0		5,544		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	13,175	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	595	0		0		10.00
11.00	MEDICAL RECORDS	3,788	0		0		11.00
12.00	STAFF TRANSPORTATION	2,310	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	146	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	54	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	181,297					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	686	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3,582	24,520	0	5,544	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	216,191	24,520	0	5,544	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-6 Part I
Date/Time Prepared: 6/12/2023 11:56 am

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	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	37,516					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,695				10.00
11.00	MEDICAL RECORDS	0		10,786			11.00
12.00	STAFF TRANSPORTATION	0			6,577		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	37,516	1,689	10,747	6,577	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	6	39	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	37,516	1,695	10,786	6,577	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-6 Part I
Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	416					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				153		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	416	0	0		573,192	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	153	2,151	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	40,263	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	416	0	0	153	615,606	100.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2022
To 12/31/2022

Worksheet O-6
Part II
Date/Time Prepared:
6/12/2023 11:56 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	585					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	236,949			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	87,687	-216,191	399,415	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	15,909	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,597	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	24,341	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	1,100	10.00
11.00	MEDICAL RECORDS	0	0	0	0	6,998	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	4,267	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	99	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			148,700	0	334,950	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	562	0	1,267	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	0	0	6,617	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	6,617	0	47,857		216,191	100.00
101.00	UNIT COST MULTIPLIER	11.311111	0.000000	0.201972		0.541269	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2022
To 12/31/2022

Worksheet O-6
Part II
Date/Time Prepared:
6/12/2023 11:56 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	585					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		585			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		7,728	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					7,728	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	585	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	24,520	0	5,544	0	37,516	100.00
101.00	UNIT COST MULTIPLIER	41.914530	0.000000	9.476923	0.000000	4.854555	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2022
To 12/31/2022

Worksheet O-6
Part II
Date/Time Prepared:
6/12/2023 11:56 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,567					10.00
11.00	MEDICAL RECORDS		3,567				11.00
12.00	STAFF TRANSPORTATION			4,267			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3,554	3,554	4,267	0	270	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	13	13	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	1,695	10,786	6,577	0	416	100.00
101.00	UNIT COST MULTIPLIER	0.475189	3.023830	1.541364	0.000000	1.540741	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2022
To 12/31/2022

Worksheet O-6
Part II
Date/Time Prepared:
6/12/2023 11:56 am

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			13		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	13		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	153		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	11.769231		101.00

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

Provider CCN: 15-0061 Hospice CCN: 15-1553

Period: From 01/01/2022 To 12/31/2022

Worksheet O-7

Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.505859	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.319240	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.518012	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.322868	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.189475	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.325701	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	1.561702	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	0.446078	0	0	0	10.00
10.01	ADDICTION SERVICES	76.01	6.691661	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC REHAB	0	0	0	0	0	10.00
10.01	ADDICTION SERVICES	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-8 | Date/Time Prepared: 6/12/2023 11:56 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			573,192	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,554	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			161.28	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,033	0		9.00
10.00	Program cost (line 8 times line 9)	489,162	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			2,151	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			13	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			165.46	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	13	0		19.00
20.00	Program cost (line 18 times line 19)	2,151	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			575,343	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,567	22.00
23.00	Average cost per diem (line 21 divided by line 22)			161.30	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0061	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	181,302	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	9.05	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	181,302	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	317,487	0	317,487	-1,111	316,376	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	132,660	0	132,660	-464	132,196	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	147,684	0	147,684	-517	147,167	9.00
10.00	Subtotal (sum of lines 1 through 9)	597,831	0	597,831	-2,092	595,739	10.00
11.00	Physician Services Under Agreement	0	1,925	1,925	0	1,925	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,925	1,925	0	1,925	14.00
15.00	Medical Supplies	0	16,299	16,299	0	16,299	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,299	16,299	0	16,299	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	597,831	18,224	616,055	-2,092	613,963	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	2,586	2,586	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	2,586	2,586	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	67,512	67,512	-236	67,276	29.00
30.00	Administrative Costs	73,770	0	73,770	-258	73,512	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,770	67,512	141,282	-494	140,788	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	671,601	85,736	757,337	0	757,337	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	316,376		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	132,196		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	147,167		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	595,739		10.00
11.00	Physician Services Under Agreement	0	1,925		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,925		14.00
15.00	Medical Supplies	0	16,299		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,299		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	613,963		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	2,586		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,586		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	67,276		29.00
30.00	Administrative Costs	0	73,512		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	140,788		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	757,337		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	272,996	0	272,996	0	272,996	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	87,413	0	87,413	0	87,413	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	100,739	0	100,739	0	100,739	9.00
10.00	Subtotal (sum of lines 1 through 9)	461,148	0	461,148	0	461,148	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	29,820	29,820	0	29,820	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,820	29,820	0	29,820	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	461,148	29,820	490,968	0	490,968	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	40,575	40,575	0	40,575	29.00
30.00	Administrative Costs	106,372	0	106,372	0	106,372	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	106,372	40,575	146,947	0	146,947	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	567,520	70,395	637,915	0	637,915	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-3999 | Date/Time Prepared: 6/12/2023 11:56 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	272,996		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	87,413		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	100,739		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	461,148		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	29,820		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,820		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	490,968		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	40,575		29.00
30.00	Administrative Costs	0	106,372		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	146,947		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	637,915		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,000	0	3,000	0	3,000	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	766,564	0	766,564	0	766,564	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	313,715	0	313,715	0	313,715	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,083,279	0	1,083,279	0	1,083,279	10.00
11.00	Physician Services Under Agreement	0	116,566	116,566	0	116,566	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	116,566	116,566	0	116,566	14.00
15.00	Medical Supplies	0	24,968	24,968	0	24,968	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,968	24,968	0	24,968	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,083,279	141,534	1,224,813	0	1,224,813	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	74,447	74,447	0	74,447	29.00
30.00	Administrative Costs	148,927	0	148,927	0	148,927	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	148,927	74,447	223,374	0	223,374	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,232,206	215,981	1,448,187	0	1,448,187	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8501 | Date/Time Prepared: 6/12/2023 11:56 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,000		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	766,564		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	313,715		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,083,279		10.00
11.00	Physician Services Under Agreement	0	116,566		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	116,566		14.00
15.00	Medical Supplies	0	24,968		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,968		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,224,813		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	74,447		29.00
30.00	Administrative Costs	0	148,927		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	223,374		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,448,187		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	481,858	0	481,858	0	481,858	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	241,524	0	241,524	0	241,524	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	155,896	0	155,896	0	155,896	9.00
10.00	Subtotal (sum of lines 1 through 9)	879,278	0	879,278	0	879,278	10.00
11.00	Physician Services Under Agreement	0	9,544	9,544	0	9,544	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,544	9,544	0	9,544	14.00
15.00	Medical Supplies	0	102,582	102,582	0	102,582	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102,582	102,582	0	102,582	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	879,278	112,126	991,404	0	991,404	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	29,611	29,611	0	29,611	29.00
30.00	Administrative Costs	59,733	0	59,733	0	59,733	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,733	29,611	89,344	0	89,344	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	939,011	141,737	1,080,748	0	1,080,748	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8503 | Date/Time Prepared: 6/12/2023 11:56 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	481,858		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	241,524		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	155,896		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	879,278		10.00
11.00	Physician Services Under Agreement	0	9,544		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,544		14.00
15.00	Medical Supplies	0	102,582		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102,582		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	991,404		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	29,611		29.00
30.00	Administrative Costs	0	59,733		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	89,344		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,080,748		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 6/12/2023 11:56 am

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	207,255	0	207,255	0	207,255	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	109,339	0	109,339	0	109,339	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	154,781	0	154,781	0	154,781	9.00
10.00	Subtotal (sum of lines 1 through 9)	471,375	0	471,375	0	471,375	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	19,689	19,689	0	19,689	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,689	19,689	0	19,689	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	471,375	19,689	491,064	0	491,064	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	36,561	36,561	0	36,561	29.00
30.00	Administrative Costs	74,547	0	74,547	0	74,547	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	74,547	36,561	111,108	0	111,108	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	545,922	56,250	602,172	0	602,172	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8506 | Date/Time Prepared: 6/12/2023 11:56 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	207,255		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	109,339		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	154,781		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	471,375		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	19,689		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,689		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	491,064		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	36,561		29.00
30.00	Administrative Costs	0	74,547		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	111,108		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	602,172		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 Date/Time Prepared: 6/12/2023 11:56 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.29	3,952	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.95	2,018	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.24	5,970		2	5,970	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.24	5,970			5,970	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					613,963	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,586	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					616,549	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995806	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					140,788	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					553,485	15.00
16.00	Total overhead (sum of lines 14 and 15)					694,273	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					694,273	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					691,361	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,305,324	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-3999 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 Date/Time Prepared: 6/12/2023 11:56 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.88	2,643	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.80	1,630	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.68	4,273		2	4,273	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.68	4,273			4,273	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					490,968	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					490,968	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					146,947	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					432,223	15.00
16.00	Total overhead (sum of lines 14 and 15)					579,170	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					579,170	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					579,170	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,070,138	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 6/12/2023 11:56 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.15	658	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	5.65	17,608	1	6		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.80	18,266		6	18,266	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.80	18,266			18,266	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,224,813	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,224,813	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					223,374	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					863,864	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,087,238	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,087,238	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,087,238	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,312,051	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8503 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 Date/Time Prepared: 6/12/2023 11:56 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.04	1,716	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.06	4,334	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.10	6,050		2	6,050	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.10	6,050			6,050	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					991,404	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					991,404	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					89,344	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					538,434	15.00
16.00	Total overhead (sum of lines 14 and 15)					627,778	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					627,778	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					627,778	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,619,182	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8506 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 Date/Time Prepared: 6/12/2023 11:56 am

RHC VI | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.06	2,545	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.02	2,564	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.08	5,109		2	5,109	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.08	5,109			5,109	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					491,064	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					491,064	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					111,108	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					374,018	15.00
16.00	Total overhead (sum of lines 14 and 15)					485,126	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					485,126	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					485,126	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					976,190	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,305,324	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		17,504	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,287,820	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,970	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,970	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.72	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	219.35	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	215.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,076	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	232,115	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	232,115	16.00
16.01	Total program charges (see instructions)(from contractor's records)		211,447	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,190	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		18,870	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		149,387	16.04
16.05	Total program cost (see instructions)	0	168,257	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,511	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,550	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		168,257	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,284	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		177,541	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		177,541	26.00
26.01	Sequestration adjustment (see instructions)		2,237	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		160,981	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		14,323	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-3999	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,070,138	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		17,058	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,053,080	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,273	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,273	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		246.45	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	204.01	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	204.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,135	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	231,551	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	231,551	16.00
16.01	Total program charges (see instructions)(from contractor's records)		242,241	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		850	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		813	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		150,254	16.04
16.05	Total program cost (see instructions)	0	151,067	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,921	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,695	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		151,067	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,048	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		155,115	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		155,115	26.00
26.01	Sequestration adjustment (see instructions)		1,955	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		142,690	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,470	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8501	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,312,051	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		9,440	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,302,611	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,266	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		18,266	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		126.06	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	156.85	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.06	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,711	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	215,689	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	215,689	16.00
16.01	Total program charges (see instructions)(from contractor's records)		314,689	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,857	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,385	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		133,202	16.04
16.05	Total program cost (see instructions)	0	138,587	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		43,801	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,607	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		138,587	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,163	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		144,750	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		144,750	26.00
26.01	Sequestration adjustment (see instructions)		1,824	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		168,208	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-25,282	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8503	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,619,182	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,619,182	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,050	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,050	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		267.63	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	335.83	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	267.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8506	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 6/12/2023 11:56 am
	Title XVIII	RHC VI	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	976,190	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	22,515	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	953,675	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	5,109	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	5,109	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	186.67	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	198.37	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	186.67	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,142	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	213,177	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	213,177	16.00
16.01	Total program charges (see instructions)(from contractor's records)		211,498	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		607	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		612	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		143,484	16.04
16.05	Total program cost (see instructions)	0	144,096	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,210	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,537	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		144,096	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,151	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		158,247	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		158,247	26.00
26.01	Sequestration adjustment (see instructions)		1,994	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		145,986	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,267	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	595,739	595,739	595,739	595,739	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000185	0.001465	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	110	873	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,838	4,412	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,948	5,285	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	613,963	613,963	613,963	613,963	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	691,361	691,361	691,361	691,361	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004802	0.008608	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,320	5,951	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,268	11,236	0	0	10.00
11.00	Total number of injections/infusions (from your records)	11	87	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	569.82	129.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	41	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,989	5,295	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		17,504	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		9,284	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4

Component CCN: 15-3999 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	461,148	461,148	461,148	461,148	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000337	0.000835	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	155	385	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,902	2,384	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,057	2,769	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490,968	490,968	490,968	490,968	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	579,170	579,170	579,170	579,170	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010300	0.005640	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,965	3,267	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11,022	6,036	0	0	10.00
11.00	Total number of injections/infusions (from your records)	19	47	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	580.11	128.43	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	27	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	580	3,468	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		17,058	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		4,048	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4

Component CCN: 15-8501 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,083,279	1,083,279	1,083,279	1,083,279	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000015	0.000568	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	16	615	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	516	3,854	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	532	4,469	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,224,813	1,224,813	1,224,813	1,224,813	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,087,238	1,087,238	1,087,238	1,087,238	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000434	0.003649	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	472	3,967	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,004	8,436	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	76	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	502.00	111.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	51	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	502	5,661	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		9,440	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6,163	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 6/12/2023 11:56 am

Title XVIII | RHC VI | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	471,375	471,375	471,375	471,375	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000221	0.002274	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	104	1,072	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,354	6,796	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,458	7,868	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	491,064	491,064	491,064	491,064	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	485,126	485,126	485,126	485,126	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007042	0.016022	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,416	7,773	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,874	15,641	0	0	10.00
11.00	Total number of injections/infusions (from your records)	13	134	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	528.77	116.72	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	85	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,230	9,921	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		22,515	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		14,151	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		160,981	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		160,981	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,323	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		175,304	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-3999	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		142,690	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		142,690	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		10,470	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		153,160	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-8501	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am

			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			168,208	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			168,208	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			25,282	6.02
7.00	Total Medicare program liability (see instructions)			142,926	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-8506	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am

			RHC VI	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			145,986	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			145,986	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			10,267	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			156,253	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00