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: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/30/2023 1:05 pm

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) 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	746,530	-281,917	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	217,925	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		52,765		0	10.00
10.01	RURAL HEALTH CLINIC II	0		79,116		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-33,727		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		40,279		0	10.03
200.00	TOTAL	0	964,455	-143,484	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 1:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: R.R 1	PO Box: 1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/01/2003	N	O	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									14.00
15.00	Hospital-Based Health Clinic - RHC	MY LINTON CLINIC	158535	99915		12/18/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MY BLOOMFIELD CLINIC	158533	99915		12/18/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MY WESTGATE CLINIC	158534	99915		12/18/2018	N	N	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	MY WORTHINGTON CLINIC	158538	99915		12/12/2018	N	N	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 1:05 pm

		1.00	2.00	3.00	
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.	0			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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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

		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

		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	

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 1:05 pm

		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.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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.	Y		108.00

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

Line	Description	1.00	Line
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

Line	Description	1.00	2.00	Line
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

Line	Description	1.00	2.00	3.00	Line
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	369,560	0	0	118.01

Line	Description	1.00	2.00	Line
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 1:05 pm

		1.00	2.00	
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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 1:05 pm

		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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2023 1:05 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/31/2023	Y	03/31/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 1:05 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	CARMACK	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS, LLP		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	ERIC.CARMACK@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 1:05 pm

		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.	MANAGING DIRECTOR		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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2023 1:05 pm

	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	20	7,300	34,752.00	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)		20	7,300	34,752.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	4,992.00	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)		25	9,125	39,744.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	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
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2023 1:05 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	833	46	1,448			1.00
2.00	HMO and other (see instructions)	149	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	243	0	273			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)	1,076	46	1,721			7.00
8.00	INTENSIVE CARE UNIT	72	10	208			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		78	113			13.00
14.00	Total (see instructions)	1,148	134	2,042	0.00	295.61	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,672	593	25,028	0.00	24.72	26.00
26.01	RURAL HEALTH CLINIC II	1,685	136	9,015	0.00	7.57	26.01
26.02	RURAL HEALTH CLINIC III	971	37	4,537	0.00	6.14	26.02
26.03	RURAL HEALTH CLINIC IV	539	68	2,578	0.00	3.63	26.03
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	337.67	27.00
28.00	Observation Bed Days		128	1,201			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	30	47			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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2023 1:05 pm

	Component	Full Time Equivalents Nonpaid Workers	Discharges 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	257	60	761	1.00
2.00	HMO and other (see instructions)			33	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	257	60	761	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC I

		1.00	
	Clinic Address and Identification		
1.00	Street	1210 N. 1000 W.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LINTON	IN	47441	2.00

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

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

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

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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	GREENE	2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC I	

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC II

		1.00	
	Clinic Address and Identification		
1.00	Street	55 N. JUDGE ST.	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BLOOMFIELD	IN	47424	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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	GREENE	2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1317 Component CCN: 15-8533	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC II	

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC III

					1.00		
	Clinic Address and Identification						
1.00	Street				1985 E. FREEDOM DR.		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		NEWBERRY		IN	47449	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				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		GREENE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8

Component CCN: 15-8534 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC III

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC IV

		1.00	
	Clinic Address and Identification		
1.00	Street	102 E. MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WORTHINGTON	IN	47471	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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	GREENE	2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC IV	

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/30/2023 1:05 pm

		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)	0.336233	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,021,105	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,198,096	5.00
6.00	Medicaid charges	35,866,470	6.00
7.00	Medicaid cost (line 1 times line 6)	12,059,491	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)	7,840,290	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)	7,840,290	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)	360,247	0	360,247	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	121,127	0	121,127	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)	121,127	0	121,127	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)	1,507,106	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	347,206	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	534,162	27.01
28.00	Non-Medicare bad debt expense (see instructions)	972,944	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	514,092	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	635,219	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,475,509	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,661,417	1,661,417	69,224	1,730,641	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		535,715	535,715	0	535,715	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,254,228	5,254,228	99,163	5,353,391	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,638,453	5,565,961	8,204,414	356,346	8,560,760	5.00
7.00	00700	OPERATION OF PLANT	760,759	1,129,644	1,890,403	0	1,890,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	279,944	279,944	8.00
9.00	00900	HOUSEKEEPING	315,813	354,296	670,109	-279,944	390,165	9.00
10.00	01000	DIETARY	640,559	382,945	1,023,504	-846,848	176,656	10.00
11.00	01100	CAFETERIA	0	0	0	846,848	846,848	11.00
13.00	01300	NURSING ADMINISTRATION	572,778	185,001	757,779	-214,881	542,898	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-90,810	-90,810	0	-90,810	14.00
15.00	01500	PHARMACY	736,961	117,189	854,150	0	854,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,693	31,006	316,699	0	316,699	16.00
17.00	01700	SOCIAL SERVICE	250,866	21,799	272,665	0	272,665	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	763,727	763,727	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,599,721	1,333,664	3,933,385	607,694	4,541,079	30.00
31.00	03100	INTENSIVE CARE UNIT	449,007	287,318	736,325	0	736,325	31.00
43.00	04300	NURSERY	0	969	969	93,584	94,553	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	581,626	519,229	1,100,855	0	1,100,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,082	828	177,910	-175,678	2,232	52.00
53.00	05300	ANESTHESIOLOGY	0	864,506	864,506	-763,727	100,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,051,567	799,138	1,850,705	0	1,850,705	54.00
60.00	06000	LABORATORY	907,183	2,627,421	3,534,604	0	3,534,604	60.00
65.00	06500	RESPIRATORY THERAPY	785,354	97,588	882,942	-4,423	878,519	65.00
66.00	06600	PHYSICAL THERAPY	552,537	59,405	611,942	0	611,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,801	0	201,801	0	201,801	67.00
68.00	06800	SPEECH PATHOLOGY	44,622	1,338	45,960	0	45,960	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,034,410	2,034,410	-1,095,371	939,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,095,371	1,095,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	254,902	2,049,047	2,303,949	0	2,303,949	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,053,231	1,250,381	4,303,612	-454,429	3,849,183	88.00
88.01	08801	RURAL HEALTH CLINIC II	782,555	334,130	1,116,685	136,466	1,253,151	88.01
88.02	08802	RURAL HEALTH CLINIC III	490,874	239,449	730,323	-13,450	716,873	88.02
88.03	08803	RURAL HEALTH CLINIC IV	342,271	157,985	500,256	1,117	501,373	88.03
91.00	09100	EMERGENCY	2,453,919	1,480,567	3,934,486	4,423	3,938,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,930,134	29,285,764	50,215,898	505,156	50,721,054	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,398,063	375,716	2,773,779	-505,156	2,268,623	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	23,328,197	29,661,480	52,989,677	0	52,989,677	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-62,168	1,668,473	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	535,715	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,353,391	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,363,843	6,196,917	5.00
7.00	00700	OPERATION OF PLANT	-3,897	1,886,506	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	279,944	8.00
9.00	00900	HOUSEKEEPING	0	390,165	9.00
10.00	01000	DIETARY	-31,535	145,121	10.00
11.00	01100	CAFETERIA	-134,874	711,974	11.00
13.00	01300	NURSING ADMINISTRATION	0	542,898	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-90,810	14.00
15.00	01500	PHARMACY	0	854,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,152	309,547	16.00
17.00	01700	SOCIAL SERVICE	0	272,665	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-519,293	244,434	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-566,709	3,974,370	30.00
31.00	03100	INTENSIVE CARE UNIT	0	736,325	31.00
43.00	04300	NURSERY	0	94,553	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,100,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,232	52.00
53.00	05300	ANESTHESIOLOGY	0	100,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,850,705	54.00
60.00	06000	LABORATORY	0	3,534,604	60.00
65.00	06500	RESPIRATORY THERAPY	-3,280	875,239	65.00
66.00	06600	PHYSICAL THERAPY	0	611,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	201,801	67.00
68.00	06800	SPEECH PATHOLOGY	0	45,960	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-79,512	859,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,095,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-274,385	2,029,564	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	3,849,183	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,253,151	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	716,873	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	501,373	88.03
91.00	09100	EMERGENCY	-944,214	2,994,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,990,862	45,730,192	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-40,214	2,228,409	192.00
194.00	07950	FOUNDATION / MOBS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,031,076	47,958,601	200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet Non-CMS W | Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	07700		77.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
88.02	RURAL HEALTH CLINIC III	08802		88.02
88.03	RURAL HEALTH CLINIC IV	08803		88.03
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
102.00	OPIOID TREATMENT PROGRAM	10200		102.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	FOUNDATION / MOBS	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	763,727	1.00
	0		0	763,727	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	175,678	0	1.00
	0		175,678	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	529,999	316,849	1.00
	0		529,999	316,849	
	D - RHC ALLOCATION				
1.00	RURAL HEALTH CLINIC	88.00	118,062	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	144,952	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	7,739	0	3.00
4.00	RURAL HEALTH CLINIC III	88.02	778	0	4.00
5.00	RURAL HEALTH CLINIC	88.00	27,356	0	5.00
6.00	RURAL HEALTH CLINIC III	88.02	5,870	0	6.00
7.00	RURAL HEALTH CLINIC II	88.01	35,390	0	7.00
8.00	RURAL HEALTH CLINIC IV	88.03	36,138	0	8.00
9.00	RURAL HEALTH CLINIC II	88.01	46,563	0	9.00
10.00	RURAL HEALTH CLINIC III	88.02	24,059	0	10.00
11.00	RURAL HEALTH CLINIC	88.00	14,301	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,444	0	12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	524,733	0	13.00
14.00		0.00	0	0	14.00
	0		1,006,385	0	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,224	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99,163	2.00
	0		0	168,387	
	F - LAUNDRY AND HOUSEKEEPING RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	279,944	1.00
	0		0	279,944	
	G - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,095,371	1.00
	0		0	1,095,371	
	I - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	525,600	0	1.00
	0		525,600	0	
	J - NURSERY RECLASS				
1.00	NURSERY	43.00	93,584	0	1.00
	0		93,584	0	
	K - EKG RECLASSIFICATION				
1.00	EMERGENCY	91.00	0	4,423	1.00
	0		0	4,423	
500.00	Grand Total: Increases		2,331,246	2,628,701	500.00

RECLASSIFICATIONS

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 1:05 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	763,727	0		1.00
	0		0	763,727			
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	175,678	0	0		1.00
	0		175,678	0			
	C - DIETARY RECLASS						
1.00	DIETARY	10.00	529,999	316,849	0		1.00
	0		529,999	316,849			
	D - RHC ALLOCATION						
1.00	NURSING ADMINISTRATION	13.00	214,881	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	48,133	0	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	7,739	0	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	778	0	0		4.00
5.00	RURAL HEALTH CLINIC III	88.02	27,356	0	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	5,870	0	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	71,528	0	0		7.00
8.00	RURAL HEALTH CLINIC	88.00	70,622	0	0		8.00
9.00	RURAL HEALTH CLINIC III	88.02	14,301	0	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	20,444	0	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	389,034	0	0		11.00
12.00	RURAL HEALTH CLINIC II	88.01	90,439	0	0		12.00
13.00	RURAL HEALTH CLINIC III	88.02	10,239	0	0		13.00
14.00	RURAL HEALTH CLINIC IV	88.03	35,021	0	0		14.00
	0		1,006,385	0			
	E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	168,387	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	168,387			
	F - LAUNDRY AND HOUSEKEEPING RECLASS						
1.00	HOUSEKEEPING	9.00	0	279,944	0		1.00
	0		0	279,944			
	G - IMPLANTABLE DEVICES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,095,371	0		1.00
	0		0	1,095,371			
	I - HOSPITALIST RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	525,600	0	0		1.00
	0		525,600	0			
	J - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	93,584	0	0		1.00
	0		93,584	0			
	K - EKG RECLASSIFICATION						
1.00	RESPIRATORY THERAPY	65.00	0	4,423	0		1.00
	0		0	4,423			
500.00	Grand Total: Decreases		2,331,246	2,628,701			500.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 Non-CMS Worksheet | Date/Time Prepared: 5/30/2023 1:05 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	763,727	ANESTHESIOLOGY	53.00	0	763,727	1.00
	0		0	763,727	0		0	763,727	
	B - LABOR & DELIVERY								
1.00	ADULTS & PEDIATRICS	30.00	175,678	0	DELIVERY ROOM & LABOR ROOM	52.00	175,678	0	1.00
	0		175,678	0	0		175,678	0	
	C - DIETARY RECLASS								
1.00	CAFETERIA	11.00	529,999	316,849	DIETARY	10.00	529,999	316,849	1.00
	0		529,999	316,849	0		529,999	316,849	
	D - RHC ALLOCATION								
1.00	RURAL HEALTH CLINIC	88.00	118,062	0	NURSING ADMINISTRATION	13.00	214,881	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	144,952	0	RURAL HEALTH CLINIC	88.00	48,133	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	7,739	0	RURAL HEALTH CLINIC	88.00	7,739	0	3.00
4.00	RURAL HEALTH CLINIC III	88.02	778	0	RURAL HEALTH CLINIC	88.00	778	0	4.00
5.00	RURAL HEALTH CLINIC	88.00	27,356	0	RURAL HEALTH CLINIC III	88.02	27,356	0	5.00
6.00	RURAL HEALTH CLINIC III	88.02	5,870	0	RURAL HEALTH CLINIC	88.00	5,870	0	6.00
7.00	RURAL HEALTH CLINIC II	88.01	35,390	0	RURAL HEALTH CLINIC	88.00	71,528	0	7.00
8.00	RURAL HEALTH CLINIC IV	88.03	36,138	0	RURAL HEALTH CLINIC	88.00	70,622	0	8.00
9.00	RURAL HEALTH CLINIC II	88.01	46,563	0	RURAL HEALTH CLINIC III	88.02	14,301	0	9.00
10.00	RURAL HEALTH CLINIC III	88.02	24,059	0	RURAL HEALTH CLINIC	88.00	20,444	0	10.00
11.00	RURAL HEALTH CLINIC	88.00	14,301	0	RURAL HEALTH CLINIC	88.00	389,034	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,444	0	RURAL HEALTH CLINIC II	88.01	90,439	0	12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	524,733	0	RURAL HEALTH CLINIC III	88.02	10,239	0	13.00
14.00		0.00	0	0	RURAL HEALTH CLINIC IV	88.03	35,021	0	14.00
	0		1,006,385	0	0		1,006,385	0	
	E - INSURANCE RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,224	ADMINISTRATIVE & GENERAL	5.00	0	168,387	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99,163		0.00	0	0	2.00
	0		0	168,387	0		0	168,387	
	F - LAUNDRY AND HOUSEKEEPING RECLASS								
1.00	LAUNDRY & LINEN SERVICE	8.00	0	279,944	HOUSEKEEPING	9.00	0	279,944	1.00
	0		0	279,944	0		0	279,944	
	G - IMPLANTABLE DEVICES RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,095,371	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,095,371	1.00
	0		0	1,095,371	0		0	1,095,371	
	I - HOSPITALIST RECLASS								
1.00	ADULTS & PEDIATRICS	30.00	525,600	0	PHYSICIANS' PRIVATE OFFICES	192.00	525,600	0	1.00
	0		525,600	0	0		525,600	0	
	J - NURSERY RECLASS								
1.00	NURSERY	43.00	93,584	0	ADULTS & PEDIATRICS	30.00	93,584	0	1.00
	0		93,584	0	0		93,584	0	
	K - EKG RECLASSIFICATION								
1.00	EMERGENCY	91.00	0	4,423	RESPIRATORY THERAPY	65.00	0	4,423	1.00
	0		0	4,423	0		0	4,423	
500.00	Grand Total: Increases		2,331,246	2,628,701	Grand Total: Decreases		2,331,246	2,628,701	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2023 1:05 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,598,975	0	0	0	974,377	1.00
2.00	Land Improvements	213,562	3,272,199	0	3,272,199	0	2.00
3.00	Buildings and Fixtures	9,090,776	1,969,874	0	1,969,874	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,445,520	673,991	0	673,991	0	5.00
6.00	Movable Equipment	4,887,770	0	0	0	326,850	6.00
7.00	HIT designated Assets	145,036	0	0	0	145,036	7.00
8.00	Subtotal (sum of lines 1-7)	20,381,639	5,916,064	0	5,916,064	1,446,263	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,381,639	5,916,064	0	5,916,064	1,446,263	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	624,598	0	1.00
2.00	Land Improvements	3,485,761	0	2.00
3.00	Buildings and Fixtures	11,060,650	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,119,511	0	5.00
6.00	Movable Equipment	4,560,920	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,851,440	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,851,440	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	776,301	487,316	397,800	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	535,715	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,312,016	487,316	397,800	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,661,417	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	535,715	2.00
3.00	Total (sum of lines 1-2)	0	2,197,132	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,290,520	0	20,290,520	0.816473	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,560,920	0	4,560,920	0.183527	0	2.00
3.00	Total (sum of lines 1-2)	24,851,440	0	24,851,440	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	714,133	487,316	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	535,715	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,249,848	487,316	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	397,800	69,224	0	0	1,668,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	535,715	2.00
3.00	Total (sum of lines 1-2)	397,800	69,224	0	0	2,204,188	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 1:05 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,897	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,514,203			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	-139,293	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,152	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	4,419	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CPR TRAINING	B	365	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC REVENUE - ADMIN	B	-19,396	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	AHA DUES	A	-2,797	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-1,288	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-230,422	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-41,182	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.07	340B EXPENSE	A	-274,385	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	CRNA TO MARKET ADJUSTMENT	A	-519,293	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.10	ORTHO CLINIC - START-UP COSTS	A	-40,214	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.10
33.11	HOSPITAL ASSESSMENT FEE	A	-2,110,287	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	BOND AMORTIZATION EXPENSE ADJUSTMENT	A	10,195	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	MISC EXPENSE - ADMIN	A	-18	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.16	INUSRANCE PROCEEDS - CAPITAL	B	-31,181	CAP REL COSTS-BLDG & FIXT	1.00	9	33.16
33.17	REBATES	B	-79,512	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.17
33.18	CATERING REVENUE	B	-31,535	DIETARY	10.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,031,076				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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2023 1:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	584,236	566,709	17,527	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	3,280	3,280	0	0	0	2.00
3.00	91.00	EMERGENCY	1,311,408	944,214	367,194	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,898,924	1,514,203	384,721		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	566,709		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	3,280		2.00
3.00	91.00	EMERGENCY	0	0	0	944,214		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,514,203		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,668,473	1,668,473				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	535,715		535,715			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,353,391	0	0	5,353,391		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,196,917	144,971	37,875	725,894	7,105,657	5.00
7.00	00700	OPERATION OF PLANT	1,886,506	217,801	56,902	174,580	2,335,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	279,944	11,595	3,029	0	294,568	8.00
9.00	00900	HOUSEKEEPING	390,165	11,572	3,023	72,473	477,233	9.00
10.00	01000	DIETARY	145,121	62,658	16,370	25,372	249,521	10.00
11.00	01100	CAFETERIA	711,974	62,658	16,370	121,625	912,627	11.00
13.00	01300	NURSING ADMINISTRATION	542,898	11,388	2,975	82,131	639,392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-90,810	78,524	20,515	0	8,229	14.00
15.00	01500	PHARMACY	854,150	29,481	7,702	169,119	1,060,452	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	309,547	24,476	6,394	65,561	405,978	16.00
17.00	01700	SOCIAL SERVICE	272,665	6,544	1,710	57,569	338,488	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	244,434	0	0	0	244,434	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,974,370	389,290	101,704	736,036	5,201,400	30.00
31.00	03100	INTENSIVE CARE UNIT	736,325	61,533	16,076	103,039	916,973	31.00
43.00	04300	NURSERY	94,553	8,702	2,273	21,476	127,004	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,100,855	112,597	29,417	133,473	1,376,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,232	4,730	1,236	322	8,520	52.00
53.00	05300	ANESTHESIOLOGY	100,779	0	0	0	100,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,850,705	104,561	27,317	241,316	2,223,899	54.00
60.00	06000	LABORATORY	3,534,604	59,949	15,662	208,182	3,818,397	60.00
65.00	06500	RESPIRATORY THERAPY	875,239	2,686	702	180,225	1,058,852	65.00
66.00	06600	PHYSICAL THERAPY	611,942	20,733	5,417	126,797	764,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,801	20,733	5,417	46,310	274,261	67.00
68.00	06800	SPEECH PATHOLOGY	45,960	11,113	2,903	10,240	70,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	859,527	0	0	0	859,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,095,371	0	0	0	1,095,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,029,564	19,241	5,027	58,495	2,112,327	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,849,183	0	37,017	596,378	4,482,578	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,253,151	0	21,559	210,899	1,485,609	88.01
88.02	08802	RURAL HEALTH CLINIC III	716,873	0	18,187	109,560	844,620	88.02
88.03	08803	RURAL HEALTH CLINIC IV	501,373	0	23,052	78,801	603,226	88.03
91.00	09100	EMERGENCY	2,994,695	130,368	34,060	563,130	3,722,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,730,192	1,607,904	519,891	4,919,003	45,219,411	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,383	1,668	0	8,051	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,228,409	54,186	14,156	434,388	2,731,139	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	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)	47,958,601	1,668,473	535,715	5,353,391	47,958,601	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,105,657					5.00
7.00	00700	OPERATION OF PLANT	406,271	2,742,060				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,235	18,838	364,641			8.00
9.00	00900	HOUSEKEEPING	83,007	18,801	0	579,041		9.00
10.00	01000	DIETARY	43,400	101,800	0	0	394,721	10.00
11.00	01100	CAFETERIA	158,736	101,800	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	111,211	18,502	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,431	127,576	0	0	0	14.00
15.00	01500	PHARMACY	184,448	47,897	0	12,524	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	70,613	39,765	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	58,874	10,631	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	42,515	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	904,680	632,470	80,794	160,745	276,289	30.00
31.00	03100	INTENSIVE CARE UNIT	159,492	99,972	18,645	63,940	118,432	31.00
43.00	04300	NURSERY	22,090	14,138	0	5,085	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	239,391	182,933	28,987	82,774	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,482	7,684	0	6,027	0	52.00
53.00	05300	ANESTHESIOLOGY	17,529	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,809	169,877	56,108	16,291	0	54.00
60.00	06000	LABORATORY	664,145	97,398	0	33,618	0	60.00
65.00	06500	RESPIRATORY THERAPY	184,169	4,364	21,665	942	0	65.00
66.00	06600	PHYSICAL THERAPY	133,039	33,684	64,521	39,927	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,703	33,684	0	1,507	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,213	18,055	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,500	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	190,521	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,403	31,260	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	779,668	230,196	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	258,396	134,067	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	146,907	113,102	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	104,921	143,355	0	0	0	88.03
91.00	09100	EMERGENCY	647,423	211,806	93,921	144,078	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,629,222	2,643,655	364,641	567,458	394,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,400	10,370	0	377	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	475,035	88,035	0	11,206	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	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)	7,105,657	2,742,060	364,641	579,041	394,721	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,173,163					11.00
13.00	01300	NURSING ADMINISTRATION	91,630	860,735				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	137,236			14.00
15.00	01500	PHARMACY	61,411	0	385	1,367,117		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,421	0	68	0	560,845	16.00
17.00	01700	SOCIAL SERVICE	19,454	0	51	0	6,445	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	253,880	442,590	3,753	0	62,730	30.00
31.00	03100	INTENSIVE CARE UNIT	37,028	64,612	520	0	6,158	31.00
43.00	04300	NURSERY	7,328	0	4	0	1,862	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,646	88,246	929	0	67,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	130	0	0	0	6,158	52.00
53.00	05300	ANESTHESIOLOGY	0	0	172	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	112,057	0	968	0	28,930	54.00
60.00	06000	LABORATORY	118,736	0	53,160	0	75,763	60.00
65.00	06500	RESPIRATORY THERAPY	75,807	0	2,200	0	15,468	65.00
66.00	06600	PHYSICAL THERAPY	60,503	0	291	0	19,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,007	0	0	0	5,156	67.00
68.00	06800	SPEECH PATHOLOGY	5,058	0	0	0	2,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,397	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	37,790	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,028	0	78	1,367,117	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	6,015	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	6,015	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	6,015	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	6,015	88.03
91.00	09100	EMERGENCY	152,133	265,287	1,361	0	237,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,122,257	860,735	134,127	1,367,117	560,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,906	0	3,109	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	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)	1,173,163	860,735	137,236	1,367,117	560,845	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	433,943					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	286,949				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	313,331	0	8,332,662	0	8,332,662	30.00
31.00	03100	INTENSIVE CARE UNIT	20,976	0	1,506,748	0	1,506,748	31.00
43.00	04300	NURSERY	0	0	177,511	0	177,511	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,311	0	2,119,445	0	2,119,445	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,287	0	52,288	0	52,288	52.00
53.00	05300	ANESTHESIOLOGY	0	286,949	405,429	0	405,429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,994,939	0	2,994,939	54.00
60.00	06000	LABORATORY	0	0	4,861,217	0	4,861,217	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,363,467	0	1,363,467	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,116,475	0	1,116,475	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	376,318	0	376,318	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	107,977	0	107,977	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	286	0	286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,041,424	0	1,041,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,323,682	0	1,323,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,896,213	0	3,896,213	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	5,498,457	0	5,498,457	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,884,087	0	1,884,087	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,110,644	0	1,110,644	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	857,517	0	857,517	88.03
91.00	09100	EMERGENCY	76,038	0	5,552,187	0	5,552,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	433,943	286,949	44,578,973	0	44,578,973	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	20,198	0	20,198	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,359,430	0	3,359,430	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	433,943	286,949	47,958,601	0	47,958,601	202.00

COST ALLOCATION STATISTICS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet Non-CMS W | Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	50	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	30	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	25	HOURS	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	144,971	37,875	182,846	0	5.00
7.00	00700	OPERATION OF PLANT	0	217,801	56,902	274,703	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,595	3,029	14,624	0	8.00
9.00	00900	HOUSEKEEPING	0	11,572	3,023	14,595	0	9.00
10.00	01000	DIETARY	0	62,658	16,370	79,028	0	10.00
11.00	01100	CAFETERIA	0	62,658	16,370	79,028	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,388	2,975	14,363	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,524	20,515	99,039	0	14.00
15.00	01500	PHARMACY	0	29,481	7,702	37,183	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,476	6,394	30,870	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,544	1,710	8,254	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	389,290	101,704	490,994	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	61,533	16,076	77,609	0	31.00
43.00	04300	NURSERY	0	8,702	2,273	10,975	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	112,597	29,417	142,014	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,730	1,236	5,966	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,561	27,317	131,878	0	54.00
60.00	06000	LABORATORY	0	59,949	15,662	75,611	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,686	702	3,388	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,733	5,417	26,150	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,733	5,417	26,150	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,113	2,903	14,016	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,241	5,027	24,268	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	37,017	37,017	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	21,559	21,559	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	18,187	18,187	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	23,052	23,052	0	88.03
91.00	09100	EMERGENCY	0	130,368	34,060	164,428	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,607,904	519,891	2,127,795	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,383	1,668	8,051	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	54,186	14,156	68,342	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	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	1,668,473	535,715	2,204,188	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	182,846					5.00
7.00	00700	OPERATION OF PLANT	10,455	285,158				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,318	1,959	17,901			8.00
9.00	00900	HOUSEKEEPING	2,136	1,955	0	18,686		9.00
10.00	01000	DIETARY	1,117	10,587	0	0	90,732	10.00
11.00	01100	CAFETERIA	4,085	10,587	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,862	1,924	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37	13,267	0	0	0	14.00
15.00	01500	PHARMACY	4,747	4,981	0	404	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,817	4,135	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,515	1,106	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,094	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,269	65,773	3,966	5,189	63,509	30.00
31.00	03100	INTENSIVE CARE UNIT	4,104	10,396	915	2,063	27,223	31.00
43.00	04300	NURSERY	568	1,470	0	164	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,161	19,024	1,423	2,671	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38	799	0	194	0	52.00
53.00	05300	ANESTHESIOLOGY	451	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,954	17,666	2,754	526	0	54.00
60.00	06000	LABORATORY	17,091	10,129	0	1,085	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,739	454	1,064	30	0	65.00
66.00	06600	PHYSICAL THERAPY	3,424	3,503	3,167	1,288	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,228	3,503	0	49	0	67.00
68.00	06800	SPEECH PATHOLOGY	314	1,878	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,847	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,903	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,455	3,251	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,064	23,939	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,650	13,942	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,781	11,762	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,700	14,908	0	0	0	88.03
91.00	09100	EMERGENCY	16,661	22,027	4,612	4,649	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,585	274,925	17,901	18,312	90,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36	1,078	0	12	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,225	9,155	0	362	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	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)	182,846	285,158	17,901	18,686	90,732	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	93,700					11.00
13.00	01300	NURSING ADMINISTRATION	7,318	26,467				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	67,607			14.00
15.00	01500	PHARMACY	4,905	0	190	52,410		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,548	0	34	0	40,404	16.00
17.00	01700	SOCIAL SERVICE	1,554	0	25	0	464	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,278	13,609	1,849	0	4,519	30.00
31.00	03100	INTENSIVE CARE UNIT	2,957	1,987	256	0	444	31.00
43.00	04300	NURSERY	585	0	2	0	134	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,045	2,714	458	0	4,891	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10	0	0	0	444	52.00
53.00	05300	ANESTHESIOLOGY	0	0	85	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,950	0	477	0	2,084	54.00
60.00	06000	LABORATORY	9,483	0	26,188	0	5,458	60.00
65.00	06500	RESPIRATORY THERAPY	6,055	0	1,084	0	1,114	65.00
66.00	06600	PHYSICAL THERAPY	4,832	0	143	0	1,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,119	0	0	0	371	67.00
68.00	06800	SPEECH PATHOLOGY	404	0	0	0	175	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15,960	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,440	0	38	52,410	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	433	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	433	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	433	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	433	88.03
91.00	09100	EMERGENCY	12,151	8,157	670	0	17,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,634	26,467	66,076	52,410	40,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,066	0	1,531	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	44,736	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,700	26,467	112,343	52,410	40,404	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	12,918					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,094				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,328		702,283	0	702,283	30.00
31.00	03100	INTENSIVE CARE UNIT	624		128,578	0	128,578	31.00
43.00	04300	NURSERY	0		13,898	0	13,898	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39		183,440	0	183,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	663		8,114	0	8,114	52.00
53.00	05300	ANESTHESIOLOGY	0		536	0	536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		174,289	0	174,289	54.00
60.00	06000	LABORATORY	0		145,045	0	145,045	60.00
65.00	06500	RESPIRATORY THERAPY	0		17,928	0	17,928	65.00
66.00	06600	PHYSICAL THERAPY	0		43,921	0	43,921	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		32,420	0	32,420	67.00
68.00	06800	SPEECH PATHOLOGY	0		16,787	0	16,787	68.00
69.00	06900	ELECTROCARDIOLOGY	0		21	0	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		19,807	0	19,807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		23,520	0	23,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		90,862	0	90,862	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		81,453	0	81,453	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		42,584	0	42,584	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		34,163	0	34,163	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		41,093	0	41,093	88.03
91.00	09100	EMERGENCY	2,264		252,758	0	252,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,918	0	2,053,500	0	2,053,500	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		9,177	0	9,177	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		95,681	0	95,681	192.00
194.00	07950	FOUNDATION / MOBS	0		0	0	0	194.00
200.00		Cross Foot Adjustments		1,094	1,094	0	1,094	200.00
201.00		Negative Cost Centers	0	0	44,736	0	44,736	201.00
202.00		TOTAL (sum lines 118 through 201)	12,918	1,094	2,204,188	0	2,204,188	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	72,668					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		89,308				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	23,328,197			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,314	6,314	3,163,186	-7,105,657	40,852,944	5.00
7.00	00700	OPERATION OF PLANT	9,486	9,486	760,759	0	2,335,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	505	0	0	294,568	8.00
9.00	00900	HOUSEKEEPING	504	504	315,813	0	477,233	9.00
10.00	01000	DIETARY	2,729	2,729	110,560	0	249,521	10.00
11.00	01100	CAFETERIA	2,729	2,729	529,999	0	912,627	11.00
13.00	01300	NURSING ADMINISTRATION	496	496	357,897	0	639,392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	3,420	0	0	8,229	14.00
15.00	01500	PHARMACY	1,284	1,284	736,961	0	1,060,452	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	285,693	0	405,978	16.00
17.00	01700	SOCIAL SERVICE	285	285	250,866	0	338,488	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	244,434	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	16,955	3,207,415	0	5,201,400	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	449,007	0	916,973	31.00
43.00	04300	NURSERY	379	379	93,584	0	127,004	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	4,904	581,626	0	1,376,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	206	1,404	0	8,520	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	100,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	1,051,567	0	2,223,899	54.00
60.00	06000	LABORATORY	2,611	2,611	907,183	0	3,818,397	60.00
65.00	06500	RESPIRATORY THERAPY	117	117	785,354	0	1,058,852	65.00
66.00	06600	PHYSICAL THERAPY	903	903	552,537	0	764,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	903	201,801	0	274,261	67.00
68.00	06800	SPEECH PATHOLOGY	484	484	44,622	0	70,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	859,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,095,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838	838	254,902	0	2,112,327	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,171	2,598,802	0	4,482,578	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,594	919,021	0	1,485,609	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,032	477,424	0	844,620	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,843	343,388	0	603,226	88.03
91.00	09100	EMERGENCY	5,678	5,678	2,453,919	0	3,722,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,030	86,670	21,435,290	-7,105,657	38,113,754	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	0	0	8,051	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,360	2,360	1,892,907	0	2,731,139	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	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)	1,668,473	535,715	5,353,391		7,105,657	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.960216	5.998511	0.229482		0.173933	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		182,846	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004476	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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	73,508					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	23,058				8.00
9.00	00900	HOUSEKEEPING	504	0	153,725			9.00
10.00	01000	DIETARY	2,729	0	0	10,232		10.00
11.00	01100	CAFETERIA	2,729	0	0	0	18,091	11.00
13.00	01300	NURSING ADMINISTRATION	496	0	0	0	1,413	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	0	0	0	0	14.00
15.00	01500	PHARMACY	1,284	0	3,325	0	947	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	0	0	685	16.00
17.00	01700	SOCIAL SERVICE	285	0	0	0	300	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	5,109	42,675	7,162	3,915	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	1,179	16,975	3,070	571	31.00
43.00	04300	NURSERY	379	0	1,350	0	113	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	1,833	21,975	0	781	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	0	1,600	0	2	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	3,548	4,325	0	1,728	54.00
60.00	06000	LABORATORY	2,611	0	8,925	0	1,831	60.00
65.00	06500	RESPIRATORY THERAPY	117	1,370	250	0	1,169	65.00
66.00	06600	PHYSICAL THERAPY	903	4,080	10,600	0	933	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	0	400	0	216	67.00
68.00	06800	SPEECH PATHOLOGY	484	0	0	0	78	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838	0	0	0	278	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,171	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,594	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,032	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,843	0	0	0	0	88.03
91.00	09100	EMERGENCY	5,678	5,939	38,250	0	2,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,870	23,058	150,650	10,232	17,306	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	100	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,360	0	2,975	0	785	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	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)	2,742,060	364,641	579,041	394,721	1,173,163	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.302879	15.814078	3.766733	38.577111	64.847880	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	285,158	17,901	18,686	90,732	93,700	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.879278	0.776347	0.121555	8.867475	5.179371	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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	158,353					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,977,807				14.00
15.00	01500	PHARMACY	0	11,167	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,973	0	97,900		16.00
17.00	01700	SOCIAL SERVICE	0	1,475	0	1,125	331	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,425	108,797	0	10,950	239	30.00
31.00	03100	INTENSIVE CARE UNIT	11,887	15,075	0	1,075	16	31.00
43.00	04300	NURSERY	0	114	0	325	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,235	26,938	0	11,850	1	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,075	17	52.00
53.00	05300	ANESTHESIOLOGY	0	4,991	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,067	0	5,050	0	54.00
60.00	06000	LABORATORY	0	1,540,809	0	13,225	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	63,756	0	2,700	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,428	0	3,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	900	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	425	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	50	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	939,039	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,095,371	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,256	100	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,050	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,050	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,050	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,050	0	88.03
91.00	09100	EMERGENCY	48,806	39,447	0	41,525	58	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,353	3,887,703	100	97,900	331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	90,104	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	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)	860,735	137,236	1,367,117	560,845	433,943	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.435546	0.034500	13,671.170000	5.728754	1,311.006042	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,467	112,343	52,410	40,404	12,918	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.167139	0.016996	524.100000	0.412707	39.027190	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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 1:05 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
		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	08803	RURAL HEALTH CLINIC IV	0	88.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	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)	286,949	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,869.490000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,094	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.940000	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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | 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	8,332,662		8,332,662	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,506,748		1,506,748	0	0	31.00
43.00	04300	NURSERY	177,511		177,511	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,119,445		2,119,445	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,288		52,288	0	0	52.00
53.00	05300	ANESTHESIOLOGY	405,429		405,429	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,994,939		2,994,939	0	0	54.00
60.00	06000	LABORATORY	4,861,217		4,861,217	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,363,467	0	1,363,467	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,116,475	0	1,116,475	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	376,318	0	376,318	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	107,977	0	107,977	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	286		286	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,041,424		1,041,424	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,323,682		1,323,682	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,896,213		3,896,213	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,498,457		5,498,457	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,884,087		1,884,087	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,110,644		1,110,644	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	857,517		857,517	0	0	88.03
91.00	09100	EMERGENCY	5,552,187		5,552,187	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,424,892		3,424,892		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	48,003,865	0	48,003,865	0	0	200.00
201.00		Less Observation Beds	3,424,892		3,424,892		0	201.00
202.00		Total (see instructions)	44,578,973	0	44,578,973	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	2,750,411		2,750,411			30.00
31.00	03100	INTENSIVE CARE UNIT	375,076		375,076			31.00
43.00	04300	NURSERY	208,650		208,650			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	977,514	5,182,198	6,159,712	0.344082	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,128	17,891	161,019	0.324732	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	198,006	660,976	858,982	0.471988	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,304	27,937,767	28,570,071	0.104828	0.000000	54.00
60.00	06000	LABORATORY	1,111,939	23,707,278	24,819,217	0.195865	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,120,431	3,204,956	4,325,387	0.315224	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	319,769	3,659,829	3,979,598	0.280550	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,768	1,208,994	1,327,762	0.283423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,203	216,612	236,815	0.455955	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,166,023	2,805,754	3,971,777	0.262206	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	416,546	792,959	1,209,505	1.094400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,253,044	12,559,496	14,812,540	0.263035	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,637,963	5,637,963			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,092,472	2,092,472			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	987,263	987,263			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	594,537	594,537			88.03
91.00	09100	EMERGENCY	599,532	26,746,792	27,346,324	0.203032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,790	1,951,613	2,158,403	1.586771	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	12,618,134	119,965,350	132,583,484			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,618,134	119,965,350	132,583,484			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 1:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,332,662		8,332,662	0	8,332,662	30.00
31.00	03100	INTENSIVE CARE UNIT	1,506,748		1,506,748	0	1,506,748	31.00
43.00	04300	NURSERY	177,511		177,511	0	177,511	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,119,445		2,119,445	0	2,119,445	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,288		52,288	0	52,288	52.00
53.00	05300	ANESTHESIOLOGY	405,429		405,429	0	405,429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,994,939		2,994,939	0	2,994,939	54.00
60.00	06000	LABORATORY	4,861,217		4,861,217	0	4,861,217	60.00
65.00	06500	RESPIRATORY THERAPY	1,363,467	0	1,363,467	0	1,363,467	65.00
66.00	06600	PHYSICAL THERAPY	1,116,475	0	1,116,475	0	1,116,475	66.00
67.00	06700	OCCUPATIONAL THERAPY	376,318	0	376,318	0	376,318	67.00
68.00	06800	SPEECH PATHOLOGY	107,977	0	107,977	0	107,977	68.00
69.00	06900	ELECTROCARDIOLOGY	286		286	0	286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,041,424		1,041,424	0	1,041,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,323,682		1,323,682	0	1,323,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,896,213		3,896,213	0	3,896,213	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,498,457		5,498,457	0	5,498,457	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,884,087		1,884,087	0	1,884,087	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,110,644		1,110,644	0	1,110,644	88.02
88.03	08803	RURAL HEALTH CLINIC IV	857,517		857,517	0	857,517	88.03
91.00	09100	EMERGENCY	5,552,187		5,552,187	0	5,552,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,424,892		3,424,892		3,424,892	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	48,003,865	0	48,003,865	0	48,003,865	200.00
201.00		Less Observation Beds	3,424,892		3,424,892		3,424,892	201.00
202.00		Total (see instructions)	44,578,973	0	44,578,973	0	44,578,973	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/30/2023 1:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,750,411		2,750,411			30.00
31.00	03100	INTENSIVE CARE UNIT	375,076		375,076			31.00
43.00	04300	NURSERY	208,650		208,650			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	977,514	5,182,198	6,159,712	0.344082	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,128	17,891	161,019	0.324732	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	198,006	660,976	858,982	0.471988	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,304	27,937,767	28,570,071	0.104828	0.000000	54.00
60.00	06000	LABORATORY	1,111,939	23,707,278	24,819,217	0.195865	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,120,431	3,204,956	4,325,387	0.315224	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	319,769	3,659,829	3,979,598	0.280550	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,768	1,208,994	1,327,762	0.283423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,203	216,612	236,815	0.455955	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,166,023	2,805,754	3,971,777	0.262206	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	416,546	792,959	1,209,505	1.094400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,253,044	12,559,496	14,812,540	0.263035	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,637,963	5,637,963	0.975256	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,092,472	2,092,472	0.900412	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	987,263	987,263	1.124973	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	594,537	594,537	1.442327	0.000000	88.03
91.00	09100	EMERGENCY	599,532	26,746,792	27,346,324	0.203032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,790	1,951,613	2,158,403	1.586771	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	12,618,134	119,965,350	132,583,484			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,618,134	119,965,350	132,583,484			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 1:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		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	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		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	183,440	6,159,712	0.029781	271,060	8,072	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,114	161,019	0.050392	0	0	52.00
53.00	05300	ANESTHESIOLOGY	536	858,982	0.000624	64,631	40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,289	28,570,071	0.006100	317,679	1,938	54.00
60.00	06000	LABORATORY	145,045	24,819,217	0.005844	571,617	3,341	60.00
65.00	06500	RESPIRATORY THERAPY	17,928	4,325,387	0.004145	566,959	2,350	65.00
66.00	06600	PHYSICAL THERAPY	43,921	3,979,598	0.011037	116,973	1,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,420	1,327,762	0.024417	18,452	451	67.00
68.00	06800	SPEECH PATHOLOGY	16,787	236,815	0.070887	7,062	501	68.00
69.00	06900	ELECTROCARDIOLOGY	21	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,807	3,971,777	0.004987	515,975	2,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,520	1,209,505	0.019446	214,710	4,175	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,862	14,812,540	0.006134	1,096,637	6,727	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,453	5,637,963	0.014447	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	42,584	2,092,472	0.020351	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	34,163	987,263	0.034604	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	41,093	594,537	0.069118	0	0	88.03
91.00	09100	EMERGENCY	252,758	27,346,324	0.009243	41,832	387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	288,653	2,158,403	0.133735	0	0	92.00
200.00		Total (lines 50 through 199)	1,497,394	129,249,347		3,803,587	31,846	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	286,949	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	286,949	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		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	6,159,712	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	161,019	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	286,949	0	858,982	0.334057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,570,071	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	24,819,217	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,325,387	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,979,598	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,327,762	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	236,815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,971,777	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,209,505	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,812,540	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,637,963	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,092,472	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	987,263	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	594,537	0.000000	88.03
91.00	09100	EMERGENCY	0	0	0	27,346,324	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,158,403	0.000000	92.00
200.00		Total (lines 50 through 199)	0	286,949	0	129,249,347		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		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	271,060	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	64,631	21,590	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	317,679	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	571,617	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	566,959	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	116,973	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,452	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,062	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	515,975	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	214,710	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,096,637	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		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	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
91.00	09100	EMERGENCY	0.000000	41,832	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,803,587	21,590	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | 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	0.344082	0	1,116,079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324732	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471988	0	149,688	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104828	0	7,471,764	0	0	54.00
60.00	06000	LABORATORY	0.195865	0	6,396,907	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.315224	0	824,020	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.280550	0	1,278,982	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.283423	0	433,234	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455955	0	24,143	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262206	0	701,376	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.094400	0	272,405	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263035	0	6,129,863	509	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.203032	0	5,192,974	227	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.586771	0	431,923	0	0	92.00
200.00		Subtotal (see instructions)		0	30,423,358	736	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	30,423,358	736	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	384,023	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	70,651	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	783,250	0	54.00
60.00	06000	LABORATORY	1,252,930	0	60.00
65.00	06500	RESPIRATORY THERAPY	259,751	0	65.00
66.00	06600	PHYSICAL THERAPY	358,818	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,788	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,008	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,905	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	298,120	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,612,369	134	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
91.00	09100	EMERGENCY	1,054,340	46	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	685,363	0	92.00
200.00		Subtotal (see instructions)	7,077,316	180	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,077,316	180	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 1:05 pm

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	0.344082	0	765,478	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324732	0	3,578	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471988	0	9,094	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104828	0	2,159,367	0	0	54.00
60.00	06000	LABORATORY	0.195865	0	2,917,931	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.315224	0	299,055	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.280550	0	178,920	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.283423	0	55,204	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455955	0	118,869	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262206	0	156,418	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.094400	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263035	0	643,483	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.203032	0	3,638,580	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.586771	0	160,582	0	0	92.00
200.00		Subtotal (see instructions)		0	11,106,559	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	11,106,559	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 1:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	263,387	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,162	0	52.00
53.00	05300	ANESTHESIOLOGY	4,292	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	226,362	0	54.00
60.00	06000	LABORATORY	571,521	0	60.00
65.00	06500	RESPIRATORY THERAPY	94,269	0	65.00
66.00	06600	PHYSICAL THERAPY	50,196	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,646	0	67.00
68.00	06800	SPEECH PATHOLOGY	54,199	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,014	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,259	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
91.00	09100	EMERGENCY	738,748	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,807	0	92.00
200.00		Subtotal (see instructions)	2,484,862	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,484,862	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	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)	2,922	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,649	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)	1,448	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	273	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)	833	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)	243	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	8,332,662	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)	778,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,554,148	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)	7,554,148	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)	2,851.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,375,466	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)	2,375,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,506,748	208	7,243.98	72	521,567	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)	1,156,238	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	4,053,271	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)	692,963	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	692,963	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)	1,201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,851.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,424,892	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	702,283	8,332,662	0.084281	3,424,892	288,653	90.00
91.00	Nursing Program cost	0	8,332,662	0.000000	3,424,892	0	91.00
92.00	Allied health cost	0	8,332,662	0.000000	3,424,892	0	92.00
93.00	All other Medical Education	0	8,332,662	0.000000	3,424,892	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 1:05 pm

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)	2,922	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,649	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)	1,448	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	273	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)	46	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)	113	15.00
16.00	Nursery days (title V or XIX only)	78	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	8,332,662	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)	778,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,554,148	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)	7,554,148	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)	2,851.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	131,178	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)	131,178	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1

Date/Time Prepared: 5/30/2023 1:05 pm

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)	177,511	113	1,570.89	78	122,529	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,506,748	208	7,243.98	10	72,440	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)	151,784	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)	477,931	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)	1,201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,851.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,424,892	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	702,283	8,332,662	0.084281	3,424,892	288,653	90.00
91.00	Nursing Program cost	0	8,332,662	0.000000	3,424,892	0	91.00
92.00	Allied health cost	0	8,332,662	0.000000	3,424,892	0	92.00
93.00	All other Medical Education	0	8,332,662	0.000000	3,424,892	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | 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		1,336,964		30.00
31.00	03100	INTENSIVE CARE UNIT		192,816		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.344082	271,060	93,267	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324732	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471988	64,631	30,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104828	317,679	33,302	54.00
60.00	06000	LABORATORY	0.195865	571,617	111,960	60.00
65.00	06500	RESPIRATORY THERAPY	0.315224	566,959	178,719	65.00
66.00	06600	PHYSICAL THERAPY	0.280550	116,973	32,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.283423	18,452	5,230	67.00
68.00	06800	SPEECH PATHOLOGY	0.455955	7,062	3,220	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262206	515,975	135,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.094400	214,710	234,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263035	1,096,637	288,454	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		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	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.203032	41,832	8,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.586771	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,803,587	1,156,238	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)		3,803,587		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.344082	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324732	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104828	17,403	1,824	54.00
60.00	06000	LABORATORY	0.195865	37,694	7,383	60.00
65.00	06500	RESPIRATORY THERAPY	0.315224	79,662	25,111	65.00
66.00	06600	PHYSICAL THERAPY	0.280550	112,002	31,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.283423	78,622	22,283	67.00
68.00	06800	SPEECH PATHOLOGY	0.455955	9,242	4,214	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262206	58,022	15,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.094400	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263035	133,703	35,169	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		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	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.203032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.586771	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		526,350	142,620	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)		526,350		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 1:05 pm

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		117,212		30.00
31.00	03100	INTENSIVE CARE UNIT		24,102		31.00
43.00	04300	NURSERY		126,795		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.344082	76,604	26,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.324732	28,626	9,296	52.00
53.00	05300	ANESTHESIOLOGY	0.471988	16,136	7,616	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104828	30,420	3,189	54.00
60.00	06000	LABORATORY	0.195865	101,250	19,831	60.00
65.00	06500	RESPIRATORY THERAPY	0.315224	56,500	17,810	65.00
66.00	06600	PHYSICAL THERAPY	0.280550	3,111	873	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.283423	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455955	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.262206	52,214	13,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.094400	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263035	91,855	24,161	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.975256	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.900412	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.124973	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.442327	0	0	88.03
91.00	09100	EMERGENCY	0.203032	142,632	28,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.586771	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		599,348	151,784	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)		599,348		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,077,496	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,077,496	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	7,148,271	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	60,469	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,802,832	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)	2,284,970	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)	2,284,970	30.00
31.00	Primary payer payments	299	31.00
32.00	Subtotal (line 30 minus line 31)	2,284,671	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)	504,130	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	327,685	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	381,321	36.00
37.00	Subtotal (see instructions)	2,612,356	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)	2,612,356	40.00
40.01	Sequestration adjustment (see instructions)	32,916	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	2,861,357	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)	-281,917	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: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00
		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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		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		2,948,597		2,861,357	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	10/17/2022	63,700		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)		63,700		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)		3,012,297		2,861,357	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		746,530		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		281,917	6.02
7.00	Total Medicare program liability (see instructions)		3,758,827		2,579,440	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: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Swing Beds - SNF | Cost

		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		549,636		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	10/17/2022	64,400		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)		64,400		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)		614,036		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		217,925		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		831,961		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: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	Hospital	Cost

		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
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	699,893	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	144,046	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	243	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	843,939	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	843,939	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	843,939	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,362	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	842,577	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	842,577	0	19.00
19.01	Sequestration adjustment (see instructions)	10,616	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	614,036	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	217,925	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part V Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,053,271	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	4,053,271	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,093,804	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,093,804	19.00
20.00	Deductibles (exclude professional component)	304,976	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,788,828	22.00
23.00	Coinsurance	1,556	23.00
24.00	Subtotal (line 22 minus line 23)	3,787,272	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,032	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	19,521	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,344	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,806,793	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,806,793	30.00
30.01	Sequestration adjustment (see instructions)	47,966	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	3,012,297	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	746,530	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2023 1:05 pm

		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	477,931		1.00
2.00	Medical and other services		2,484,862	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	477,931	2,484,862	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)	477,931	2,484,862	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	599,348	11,106,559	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)	599,348	11,106,559	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)	599,348	11,106,559	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	121,417	8,621,697	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)	477,931	2,484,862	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)	477,931	2,484,862	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)	477,931	2,484,862	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)	477,931	2,484,862	36.00
37.00	TO ZERO OUT MEDICAID	-477,931	-2,484,862	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
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/30/2023 1:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,471,847	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	6,443,554	0	0	0	4.00
5.00	Other receivable	2,430,393	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	546,449	0	0	0	7.00
8.00	Prepaid expenses	295,516	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)	13,187,759	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	624,598	0	0	0	12.00
13.00	Land improvements	3,485,761	0	0	0	13.00
14.00	Accumulated depreciation	-126,396	0	0	0	14.00
15.00	Buildings	11,060,650	0	0	0	15.00
16.00	Accumulated depreciation	-2,167,877	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,119,511	0	0	0	19.00
20.00	Accumulated depreciation	-2,273,029	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	4,560,920	0	0	0	23.00
24.00	Accumulated depreciation	-1,589,209	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)	18,694,929	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,206,428	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	2,927,586	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,134,014	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,016,702	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,155,467	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,463,286	0	0	0	38.00
39.00	Payroll taxes payable	338,164	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,847,296	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	2,108,159	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,912,372	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,246,058	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,246,058	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,158,430	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,858,272				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)	10,858,272	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,016,702	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1317

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

Worksheet G-1

Date/Time Prepared: 5/30/2023 1:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,049,325		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,580,807				2.00
3.00	Total (sum of line 1 and line 2)		9,468,518		0		3.00
4.00	INTERCOMPANY TRANSFERS	1,389,754		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,389,754		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,858,272		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)		10,858,272		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	INTERCOMPANY TRANSFERS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		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: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2023 1:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,709,018		2,709,018	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	2,709,018		2,709,018	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	375,076		375,076	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)	375,076		375,076	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,084,094		3,084,094	17.00
18.00	Ancillary services	10,582,029	119,236,306	129,818,335	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	5,637,963	5,637,963	20.00
20.01	RURAL HEALTH CLINIC II	0	2,092,472	2,092,472	20.01
20.02	RURAL HEALTH CLINIC III	0	987,263	987,263	20.02
20.03	RURAL HEALTH CLINIC IV	0	594,537	594,537	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,666,123	128,548,541	142,214,664	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,989,677		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	1,238,583			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)		1,238,583		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)		54,228,260		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/30/2023 1:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	142,214,664	1.00
2.00	Less contractual allowances and discounts on patients' accounts	94,318,776	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,895,888	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	54,228,260	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,332,372	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	2,287,212	24.00
24.50	COVID-19 PHE Funding	464,353	24.50
25.00	Total other income (sum of lines 6-24)	2,751,565	25.00
26.00	Total (line 5 plus line 25)	-3,580,807	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)	-3,580,807	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8535 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC I

		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	3,053,231	0	3,053,231	-1,731,569	1,321,662	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	749,391	749,391	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	88,353	88,353	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	852,857	852,857	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,053,231	0	3,053,231	-40,968	3,012,263	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	875,768	875,768	0	875,768	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	875,768	875,768	0	875,768	14.00
15.00	Medical Supplies	0	196,559	196,559	0	196,559	15.00
16.00	Transportation (Health Care Staff)	0	26,826	26,826	0	26,826	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	223,385	223,385	0	223,385	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,053,231	1,099,153	4,152,384	-40,968	4,111,416	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	101,731	101,731	0	101,731	29.00
30.00	Administrative Costs	0	49,497	49,497	40,968	90,465	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	151,228	151,228	40,968	192,196	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,053,231	1,250,381	4,303,612	0	4,303,612	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1
Component CCN: 15-8535 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-339,549	982,113	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-37,482	711,909	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	-77,398	10,955	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	852,857	9.00
10.00	Subtotal (sum of lines 1 through 9)	-454,429	2,557,834	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	875,768	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	875,768	14.00
15.00	Medical Supplies	0	196,559	15.00
16.00	Transportation (Health Care Staff)	0	26,826	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	223,385	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-454,429	3,656,987	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	101,731	29.00
30.00	Administrative Costs	0	90,465	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	192,196	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-454,429	3,849,183	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC II

		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	782,555	0	782,555	-367,504	415,051	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	169,376	169,376	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	0	0	0	198,128	198,128	9.00
10.00	Subtotal (sum of lines 1 through 9)	782,555	0	782,555	0	782,555	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	155,505	155,505	0	155,505	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	155,505	155,505	0	155,505	14.00
15.00	Medical Supplies	0	94,043	94,043	0	94,043	15.00
16.00	Transportation (Health Care Staff)	0	864	864	0	864	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	94,907	94,907	0	94,907	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	782,555	250,412	1,032,967	0	1,032,967	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	71,053	71,053	0	71,053	29.00
30.00	Administrative Costs	0	12,665	12,665	0	12,665	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	83,718	83,718	0	83,718	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	782,555	334,130	1,116,685	0	1,116,685	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1317 Component CCN: 15-8533	Period: From 01/01/2022 To 12/31/2022	Worksheet M-1 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC II	

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	54,513	469,564	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	46,563	215,939	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	35,390	35,390	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	198,128	9.00
10.00	Subtotal (sum of lines 1 through 9)	136,466	919,021	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	155,505	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	155,505	14.00
15.00	Medical Supplies	0	94,043	15.00
16.00	Transportation (Health Care Staff)	0	864	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	94,907	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	136,466	1,169,433	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	71,053	29.00
30.00	Administrative Costs	0	12,665	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	83,718	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	136,466	1,253,151	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC III

		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	490,874	0	490,874	-339,966	150,908	1.00
2.00	Physician Assistant	0	0	0	104,680	104,680	2.00
3.00	Nurse Practitioner	0	0	0	235,286	235,286	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	490,874	0	490,874	0	490,874	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	98,834	98,834	0	98,834	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	98,834	98,834	0	98,834	14.00
15.00	Medical Supplies	0	70,476	70,476	0	70,476	15.00
16.00	Transportation (Health Care Staff)	0	2,474	2,474	0	2,474	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	72,950	72,950	0	72,950	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	490,874	171,784	662,658	0	662,658	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	54,833	54,833	0	54,833	29.00
30.00	Administrative Costs	0	12,832	12,832	0	12,832	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,665	67,665	0	67,665	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	490,874	239,449	730,323	0	730,323	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-10,239	140,669	1.00
2.00	Physician Assistant	0	104,680	2.00
3.00	Nurse Practitioner	-9,081	226,205	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	5,870	5,870	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-13,450	477,424	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	98,834	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	98,834	14.00
15.00	Medical Supplies	0	70,476	15.00
16.00	Transportation (Health Care Staff)	0	2,474	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	72,950	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-13,450	649,208	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	54,833	29.00
30.00	Administrative Costs	0	12,832	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,665	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,450	716,873	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC IV

		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	342,271	0	342,271	-218,672	123,599	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	218,672	218,672	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	342,271	0	342,271	0	342,271	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	79,047	79,047	0	79,047	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	79,047	79,047	0	79,047	14.00
15.00	Medical Supplies	0	32,705	32,705	0	32,705	15.00
16.00	Transportation (Health Care Staff)	0	3,051	3,051	0	3,051	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	35,756	35,756	0	35,756	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	342,271	114,803	457,074	0	457,074	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	34,203	34,203	0	34,203	29.00
30.00	Administrative Costs	0	8,979	8,979	0	8,979	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	43,182	43,182	0	43,182	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	342,271	157,985	500,256	0	500,256	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC IV

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-35,021	88,578	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	218,672	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	36,138	36,138	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,117	343,388	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	79,047	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	79,047	14.00
15.00	Medical Supplies	0	32,705	15.00
16.00	Transportation (Health Care Staff)	0	3,051	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	35,756	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,117	458,191	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	34,203	29.00
30.00	Administrative Costs	0	8,979	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	43,182	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,117	501,373	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC I

		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	3.55	6,826	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	6.03	18,123	1	6		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.58	24,949		10	24,949	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	0.13	79			79	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)	9.71	25,028			25,028	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	3,656,987	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)	3,656,987	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)	192,196	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,649,274	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,841,470	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,841,470	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,841,470	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	5,498,457	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC II

		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	1.51	3,890	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.41	4,699	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.92	8,589		3	8,589	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	0.54	426			426	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.46	9,015			9,015	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)	1,169,433	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)	1,169,433	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)	83,718	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	630,936	15.00
16.00	Total overhead (sum of lines 14 and 15)	714,654	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	714,654	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	714,654	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,884,087	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC III

		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	0.44	984	1	0		1.00
2.00	Physician Assistant	0.37	0	1	0		2.00
3.00	Nurse Practitioner	1.65	3,495	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.46	4,479		2	4,479	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	0.10	58			58	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)	2.56	4,537			4,537	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)	649,208	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)	649,208	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)	67,665	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	393,771	15.00
16.00	Total overhead (sum of lines 14 and 15)	461,436	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	461,436	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	461,436	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,110,644	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC IV

		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	0.90	42	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.21	2,101	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.11	2,143		3	2,143	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	0.52	435			435	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.63	2,578			2,578	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)	458,191	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)	458,191	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)	43,182	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	356,144	15.00
16.00	Total overhead (sum of lines 14 and 15)	399,326	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	399,326	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	399,326	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	857,517	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	RHC I	

			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)		5,498,457	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		305,844	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		5,192,613	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		25,028	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		25,028	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		207.47	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	220.63	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	207.47	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,672	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	761,830	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	761,830	16.00
16.01	Total program charges (see instructions)(from contractor's records)		704,137	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		95,307	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		103,116	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.)		465,715	16.04
16.05	Total program cost (see instructions)	0	568,831	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		76,570	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		106,544	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		568,831	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		92,447	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		661,278	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)		661,278	26.00
26.01	Sequestration adjustment (see instructions)		8,332	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		600,181	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)		52,765	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: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-3 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | RHC II

Line	Description		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)		1,884,087	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		286,310	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,597,777	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,015	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)		9,015	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		177.24	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	185.01	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	177.24	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,685	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	298,649	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	298,649	16.00
16.01	Total program charges (see instructions)(from contractor's records)		357,713	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,417	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,697	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.)		194,274	16.04
16.05	Total program cost (see instructions)	0	202,971	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		47,110	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		60,036	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		202,971	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		89,476	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		292,447	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)		292,447	26.00
26.01	Sequestration adjustment (see instructions)		3,685	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		209,646	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)		79,116	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: 15-1317 Component CCN: 15-8534	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	RHC III	

			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)		1,110,644	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		57,635	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,053,009	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,537	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)		4,537	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		232.09	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	303.50	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	232.09	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	971	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	225,359	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	225,359	16.00
16.01	Total program charges (see instructions)(from contractor's records)		221,918	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,573	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,752	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.)		161,447	16.04
16.05	Total program cost (see instructions)	0	173,199	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,798	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,709	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		173,199	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,841	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		194,040	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)		194,040	26.00
26.01	Sequestration adjustment (see instructions)		2,445	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		225,322	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)		-33,727	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: 15-1317 Component CCN: 15-8538	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	RHC IV	

			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)		857,517	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		98,257	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		759,260	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,578	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)		2,578	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		294.52	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	163.22	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	163.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	539	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	87,976	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	87,976	16.00
16.01	Total program charges (see instructions)(from contractor's records)		105,086	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,954	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,636	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.)		53,784	16.04
16.05	Total program cost (see instructions)	0	55,420	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,110	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,804	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		55,420	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		40,163	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		95,583	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)		95,583	26.00
26.01	Sequestration adjustment (see instructions)		1,204	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		54,100	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)		40,279	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: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | RHC I

		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)	2,557,834	2,557,834	2,557,834	2,557,834	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001532	0.006470	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,919	16,549	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	92,195	90,752	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	96,114	107,301	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,656,987	3,656,987	3,656,987	3,656,987	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,841,470	1,841,470	1,841,470	1,841,470	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026282	0.029341	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	48,398	54,031	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	144,512	161,332	0	0	10.00
11.00	Total number of injections/infusions (from your records)	500	2,111	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	289.02	76.42	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	93	858	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)	26,879	65,568	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)		305,844	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)		92,447	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/30/2023 1:05 pm

Title XVIII | RHC II

		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)	919,021	919,021	919,021	919,021	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.006259	0.023224	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,752	21,343	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	78,011	72,603	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	83,763	93,946	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,169,433	1,169,433	1,169,433	1,169,433	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	714,654	714,654	714,654	714,654	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.071627	0.080335	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	51,189	57,412	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	134,952	151,358	0	0	10.00
11.00	Total number of injections/infusions (from your records)	463	1,718	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	291.47	88.10	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	122	612	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)	35,559	53,917	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)		286,310	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)		89,476	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-1317 Component CCN: 15-8534	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	RHC III	

		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)	477,424	477,424	477,424	477,424	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001175	0.008243	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	561	3,935	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,053	20,141	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,614	24,076	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	649,208	649,208	649,208	649,208	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	461,436	461,436	461,436	461,436	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014809	0.037085	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,833	17,112	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,447	41,188	0	0	10.00
11.00	Total number of injections/infusions (from your records)	60	421	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	274.12	97.83	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	171	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)	4,112	16,729	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)		57,635	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)		20,841	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/30/2023 1:05 pm
	Title XVIII	RHC IV	

		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)	343,388	343,388	343,388	343,388	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000630	0.009701	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	216	3,331	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,567	38,387	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,783	41,718	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	458,191	458,191	458,191	458,191	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	399,326	399,326	399,326	399,326	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.023534	0.091049	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,398	36,358	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,181	78,076	0	0	10.00
11.00	Total number of injections/infusions (from your records)	59	909	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	342.05	85.89	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	22	380	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)	7,525	32,638	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)		98,257	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)		40,163	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/30/2023 1:05 pm

RHC I

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		600,181	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)		600,181	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		52,765	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		652,946	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: 15-1317 Component CCN: 15-8533	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		209,646	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)		209,646	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		79,116	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		288,762	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: 15-1317 Component CCN: 15-8534	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		225,322	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)		225,322	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		33,727	6.02
7.00	Total Medicare program liability (see instructions)		191,595	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: 15-1317 Component CCN: 15-8538	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/30/2023 1:05 pm
		RHC IV	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		54,100	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)		54,100	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		40,279	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		94,379	7.00

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