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: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/15/2023 9:14 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/15/2023 Time: 9:14 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) 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	Ralph Mercuri		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ralph Mercuri			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	359,858	-33,838	0	-207,909	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-861		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-20,924		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-306,057		0	10.02
200.00	TOTAL	0	359,858	-361,680	0	-207,909	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2023 9:14 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2451 INTELLIPLEX DR	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IN	Zip Code: 46176-	County: SHELBY	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	MAJOR HOSPITAL	150097	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MHP PEDIATRICS	158529	99915		01/29/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MHP OB/GYN	158531	99915		01/29/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MHP FAMILY & INTERNAL MEDICINE	158532	99915		01/29/2018	N	N	N	15.02
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	8		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	277	659	0	0	1,386	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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
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	
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

		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

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	451,893	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/15/2023 9:14 am

		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 (SPECIFY)					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)	9.99	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/15/2023 9:14 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/20/2023	Y	02/20/2023	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/15/2023 9:14 am

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/15/2023 9:14 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2023 9:14 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	387	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)		46	16,790	0.00	387	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER (SPECIFY)						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		46				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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2023 9:14 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,463	271	7,910			1.00
2.00	HMO and other (see instructions)	3,299	2,012				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,463	271	7,910			7.00
8.00	INTENSIVE CARE UNIT	387	0	1,806			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)	2,850	271	9,716	0.00	712.03	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 (SPECIFY)						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			6			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	31	725	22,759	0.00	25.79	26.00
26.01	RURAL HEALTH CLINIC II	204	121	8,626	0.00	13.20	26.01
26.02	RURAL HEALTH CLINIC III	14,830	775	65,965	0.00	98.36	26.02
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	849.38	27.00
28.00	Observation Bed Days		30	1,338			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	39	60			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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/15/2023 9:14 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	771	53	2,414	1.00
2.00	HMO and other (see instructions)			695	502		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	771	53	2,414	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER (SPECIFY)						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/15/2023 9:14 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	66,623,237	-532,329	66,090,908	1,722,409.00	38.37	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		647,915	0	647,915	3,259.00	198.81	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,591,662	0	2,591,662	13,037.00	198.79	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		8,428,477	0	8,428,477	285,396.00	29.53	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,609,617	88,796	3,698,413	49,094.00	75.33	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		811,116	0	811,116	7,176.00	113.03	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		337,980	0	337,980	1,353.00	249.80	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,483,992	0	12,483,992			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		583,730	0	583,730			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		67,504	0	67,504			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		270,026	0	270,026			23.00
24.00	Wage-related costs (RHC/FQHC)		2,343,568	0	2,343,568			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	693,406	-1,974	691,432	11,587.75	59.67	26.00
27.00	Administrative & General	5.00	10,302,899	-171,129	10,131,770	244,450.94	41.45	27.00
28.00	Administrative & General under contract (see inst.)		487,398	0	487,398	2,312.00	210.81	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,488,358	-469	1,487,889	36,640.52	40.61	30.00
31.00	Laundry & Linen Service	8.00	122,496	-174	122,322	6,591.58	18.56	31.00
32.00	Housekeeping	9.00	1,833,269	-16,337	1,816,932	95,581.88	19.01	32.00
33.00	Housekeeping under contract (see instructions)		206,214	0	206,214	2,080.00	99.14	33.00
34.00	Dietary	10.00	1,129,855	-923,406	206,449	10,540.66	19.59	34.00
35.00	Dietary under contract (see instructions)		199,251	0	199,251	2,080.00	95.79	35.00
36.00	Cafeteria	11.00	0	902,528	902,528	47,283.00	19.09	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	813,815	-5,985	807,830	19,114.35	42.26	38.00
39.00	Central Services and Supply	14.00	330,400	-330,400	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,276,773	-33,124	1,243,649	26,189.85	47.49	40.00
41.00	Medical Records & Medical Records Library	16.00	1,514,360	-15,296	1,499,064	55,884.48	26.82	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/15/2023 9:14 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		56,495,961	-532,329	55,963,632	1,430,448.00	39.12	1.00
2.00	Excluded area salaries (see instructions)		3,609,617	88,796	3,698,413	49,094.00	75.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		52,886,344	-621,125	52,265,219	1,381,354.00	37.84	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,149,096	0	1,149,096	8,529.00	134.73	4.00
5.00	Subtotal wage-related costs (see inst.)		12,551,496	0	12,551,496	0.00	24.02	5.00
6.00	Total (sum of lines 3 thru 5)		66,586,936	-621,125	65,965,811	1,389,883.00	47.46	6.00
7.00	Total overhead cost (see instructions)		20,398,494	-595,766	19,802,728	560,337.01	35.34	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/15/2023 9:14 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,773,340	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	7,946,347	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	51,456	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	84,547	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	149,766	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	113,152	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,688,416	17.00
18.00	Medicare Taxes - Employers Portion Only	929,108	18.00
19.00	Unemployment Insurance	2,642	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,046	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,748,820	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	811,116	15,748,820	1.00
2.00	Hospital	811,116	15,748,820	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8

Component CCN: 15-8529 | Date/Time Prepared: 5/15/2023 9:14 am

RHC I

		1.00	
	Clinic Address and Identification		
1.00	Street	2451 INTELLIPLEX DRIVE, SUITE 240	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IN	46176	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			07:30	17:00	07:30	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	SHELBY	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	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8
Component CCN: 15-8529 | Date/Time Prepared: 5/15/2023 9:14 am

RHC I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/15/2023 9:14 am
		RHC II	

		1.00	
	Clinic Address and Identification		
1.00	Street	2451 INTELLIPLEX DRIVE, SUITE 230	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IN	46176	2.00

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

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

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

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

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8

Component CCN: 15-8531 | Date/Time Prepared: 5/15/2023 9:14 am

RHC II

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/15/2023 9:14 am
		RHC III	

		1.00	
	Clinic Address and Identification		
1.00	Street	2451 INTELLIPLEX DRIVE, SUITE 260	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IN	46176	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			07:00	17:00	07:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/15/2023 9:14 am
		RHC III	

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/15/2023 9:14 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.258940	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,282,064	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	99,570,095	6.00
7.00	Medicaid cost (line 1 times line 6)	25,782,680	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)	15,500,616	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)	15,500,616	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)	5,460,250	549,701	6,009,951	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,413,877	549,701	1,963,578	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)	1,413,877	549,701	1,963,578	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)	7,961,812	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	192,188	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	295,673	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,666,139	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,088,555	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,052,133	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	19,552,749	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		17,099,936	17,099,936	0	17,099,936	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	693,406	11,385,530	12,078,936	0	12,078,936	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,302,899	22,667,150	32,970,049	-245,409	32,724,640	5.00
7.00	00700	OPERATION OF PLANT	1,488,358	2,394,102	3,882,460	0	3,882,460	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,496	276,667	399,163	0	399,163	8.00
9.00	00900	HOUSEKEEPING	1,833,269	1,050,473	2,883,742	0	2,883,742	9.00
10.00	01000	DIETARY	1,129,855	1,524,896	2,654,751	-2,130,891	523,860	10.00
11.00	01100	CAFETERIA	0	0	0	2,130,891	2,130,891	11.00
13.00	01300	NURSING ADMINISTRATION	813,815	428,002	1,241,817	0	1,241,817	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	330,400	394,261	724,661	-724,661	0	14.00
15.00	01500	PHARMACY	1,276,773	14,401,175	15,677,948	0	15,677,948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,514,360	508,783	2,023,143	0	2,023,143	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,890,009	1,553,099	8,443,108	17,994	8,461,102	30.00
31.00	03100	INTENSIVE CARE UNIT	2,200,163	691,563	2,891,726	0	2,891,726	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,932,849	5,825,269	8,758,118	-2,565,136	6,192,982	50.00
53.00	05300	ANESTHESIOLOGY	3,356,558	255,848	3,612,406	48,060	3,660,466	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,386,915	2,218,187	5,605,102	0	5,605,102	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,564,815	1,033,856	2,598,671	0	2,598,671	56.01
57.00	05700	CT SCAN	580,764	1,591,040	2,171,804	0	2,171,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	545,738	333,088	878,826	0	878,826	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,377,193	4,617,609	6,994,802	0	6,994,802	60.00
65.00	06500	RESPIRATORY THERAPY	1,662,902	292,641	1,955,543	0	1,955,543	65.00
65.01	06501	SLEEP LAB	450,717	145,178	595,895	0	595,895	65.01
66.00	06600	PHYSICAL THERAPY	2,181,724	275,910	2,457,634	0	2,457,634	66.00
69.00	06900	ELECTROCARDIOLOGY	680,650	1,378,453	2,059,103	0	2,059,103	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,975,481	2,975,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,469,473	1,284,343	2,753,816	70,630	2,824,446	88.00
88.01	08801	RURAL HEALTH CLINIC II	731,464	1,284,379	2,015,843	0	2,015,843	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,227,540	5,428,374	11,655,914	0	11,655,914	88.02
90.00	09000	CLINIC	1,457,156	642,404	2,099,560	0	2,099,560	90.00
91.00	09100	EMERGENCY	3,291,694	1,808,105	5,099,799	296,322	5,396,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,519,665	347,587	1,867,252	0	1,867,252	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,013,620	103,137,908	166,151,528	-126,719	166,024,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	UROLOGY	7,150	41,334	48,484	0	48,484	190.01
190.02	19002	MEDICAL SPECIALITIES	193,672	705,767	899,439	-48,060	851,379	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	245,409	245,409	190.05
190.06	19006	YMCA/WELLNESS CENTER	9,361	34,801	44,162	0	44,162	190.06
190.07	19007	I-74 CAMPUS	0	610	610	0	610	190.07
190.08	19008	RAMPART	76,479	62,937	139,416	0	139,416	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	34	21,712	21,746	0	21,746	190.09
190.11	19011	MHP ADMIN BUILDING	44,857	51,250	96,107	0	96,107	190.11
190.16	19016	RENOVO	47,814	50,085	97,899	0	97,899	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,007,456	539,542	3,546,998	-70,630	3,476,368	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	6,966	6,966	0	6,966	192.02
194.00	07950	UNAVIE	222,794	82,634	305,428	0	305,428	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	66,623,237	104,735,546	171,358,783	0	171,358,783	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,272,195	13,827,741	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,025	12,069,911	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,586,726	19,137,914	5.00
7.00	00700	OPERATION OF PLANT	0	3,882,460	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	399,163	8.00
9.00	00900	HOUSEKEEPING	0	2,883,742	9.00
10.00	01000	DIETARY	-38,877	484,983	10.00
11.00	01100	CAFETERIA	-539,383	1,591,508	11.00
13.00	01300	NURSING ADMINISTRATION	-2,270	1,239,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	15,677,948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,023,143	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-4,373	8,456,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,891,726	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	6,192,982	50.00
53.00	05300	ANESTHESIOLOGY	-3,454,961	205,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-661,992	4,943,110	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	-242,780	2,355,891	56.01
57.00	05700	CT SCAN	-839,967	1,331,837	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	878,826	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-132,401	6,862,401	60.00
65.00	06500	RESPIRATORY THERAPY	-561	1,954,982	65.00
65.01	06501	SLEEP LAB	0	595,895	65.01
66.00	06600	PHYSICAL THERAPY	-78,670	2,378,964	66.00
69.00	06900	ELECTROCARDIOLOGY	-59,027	2,000,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,975,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	840,953	3,665,399	88.00
88.01	08801	RURAL HEALTH CLINIC II	-42,391	1,973,452	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,720,547	14,376,461	88.02
90.00	09000	CLINIC	-1,438	2,098,122	90.00
91.00	09100	EMERGENCY	-804,127	4,591,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,867,252	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,209,664	145,815,145	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	UROLOGY	0	48,484	190.01
190.02	19002	MEDICAL SPECIALITIES	0	851,379	190.02
190.03	19003	UNUSED	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	190.04
190.05	19005	MARKETING	0	245,409	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	44,162	190.06
190.07	19007	I-74 CAMPUS	0	610	190.07
190.08	19008	RAMPART	0	139,416	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	21,746	190.09
190.11	19011	MHP ADMIN BUILDING	0	96,107	190.11
190.16	19016	RENOVO	0	97,899	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	3,476,368	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	6,966	192.02
194.00	07950	UNAVIE	0	305,428	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,209,664	151,149,119	200.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/15/2023 9:14 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	902,528	1,228,363	1.00
	0		902,528	1,228,363	
	B - CS&R OTHER				
1.00	ADULTS & PEDIATRICS	30.00	8,204	9,790	1.00
2.00	OPERATING ROOM	50.00	187,092	223,253	2.00
3.00	EMERGENCY	91.00	135,104	161,218	3.00
	0		330,400	394,261	
	C - MARKETING				
1.00	MARKETING	190.05	107,376	138,033	1.00
	0		107,376	138,033	
	D - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	115,878	2,859,603	1.00
	0		115,878	2,859,603	
	E - RHC RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	0	70,630	1.00
	0		0	70,630	
	F - SHORT TERM DISABILITY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,974	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	63,753	2.00
3.00	OPERATION OF PLANT	7.00	0	469	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	174	4.00
5.00	HOUSEKEEPING	9.00	0	16,337	5.00
6.00	DIETARY	10.00	0	20,878	6.00
7.00	NURSING ADMINISTRATION	13.00	0	5,985	7.00
9.00	PHARMACY	15.00	0	33,124	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,296	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	63,072	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	14,083	12.00
13.00	OPERATING ROOM	50.00	0	25,270	13.00
14.00	ANESTHESIOLOGY	53.00	0	277	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,631	15.00
16.00	ONCOLOGY	56.01	0	19,924	16.00
17.00	CT SCAN	57.00	0	1,731	17.00
19.00	LABORATORY	60.00	0	23,851	19.00
20.00	RESPIRATORY THERAPY	65.00	0	8,463	20.00
21.00	SLEEP LAB	65.01	0	1,158	21.00
22.00	PHYSICAL THERAPY	66.00	0	11,338	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	3,859	23.00
24.00	RURAL HEALTH CLINIC	88.00	0	19,530	24.00
25.00	RURAL HEALTH CLINIC II	88.01	0	10,438	25.00
26.00	RURAL HEALTH CLINIC III	88.02	0	72,710	26.00
27.00	CLINIC	90.00	0	15,940	27.00
28.00	EMERGENCY	91.00	0	20,027	28.00
29.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	9,457	29.00
30.00	RAMPART	190.08	0	556	30.00
31.00	MEDICAL SPECIALITIES	190.02	0	5,582	31.00
32.00	HOSPITALIST	192.01	0	5,385	32.00
33.00	UNAVIE	194.00	0	7,057	33.00
	TOTALS		0	532,329	
	G - PAIN MANAGEMENT MEDICAL DIRECTOR				
1.00	ANESTHESIOLOGY	53.00	0	48,060	1.00
	TOTALS		0	48,060	
500.00	Grand Total: Increases		1,456,182	5,271,279	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	902,528	1,228,363	0	1.00
	0		902,528	1,228,363		
	B - CS&R OTHER					
1.00	CENTRAL SERVICES & SUPPLY	14.00	330,400	394,261	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		330,400	394,261		
	C - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	107,376	138,033	0	1.00
	0		107,376	138,033		
	D - IMPLANTABLE DEVICES RECLASS					
1.00	OPERATING ROOM	50.00	115,878	2,859,603	0	1.00
	0		115,878	2,859,603		
	E - RHC RECLASS					
1.00	HOSPITALIST	192.01	0	70,630	0	1.00
	0		0	70,630		
	F - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,974	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	63,753	0	0	2.00
3.00	OPERATION OF PLANT	7.00	469	0	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	174	0	0	4.00
5.00	HOUSEKEEPING	9.00	16,337	0	0	5.00
6.00	DIETARY	10.00	20,878	0	0	6.00
7.00	NURSING ADMINISTRATION	13.00	5,985	0	0	7.00
9.00	PHARMACY	15.00	33,124	0	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	15,296	0	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	63,072	0	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	14,083	0	0	12.00
13.00	OPERATING ROOM	50.00	25,270	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	277	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	34,631	0	0	15.00
16.00	ONCOLOGY	56.01	19,924	0	0	16.00
17.00	CT SCAN	57.00	1,731	0	0	17.00
19.00	LABORATORY	60.00	23,851	0	0	19.00
20.00	RESPIRATORY THERAPY	65.00	8,463	0	0	20.00
21.00	SLEEP LAB	65.01	1,158	0	0	21.00
22.00	PHYSICAL THERAPY	66.00	11,338	0	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	3,859	0	0	23.00
24.00	RURAL HEALTH CLINIC	88.00	19,530	0	0	24.00
25.00	RURAL HEALTH CLINIC II	88.01	10,438	0	0	25.00
26.00	RURAL HEALTH CLINIC III	88.02	72,710	0	0	26.00
27.00	CLINIC	90.00	15,940	0	0	27.00
28.00	EMERGENCY	91.00	20,027	0	0	28.00
29.00	OBSERVATION BEDS (DISTINCT PART)	92.01	9,457	0	0	29.00
30.00	RAMPART	190.08	556	0	0	30.00
31.00	MEDICAL SPECIALITIES	190.02	5,582	0	0	31.00
32.00	HOSPITALIST	192.01	5,385	0	0	32.00
33.00	UNAVIE	194.00	7,057	0	0	33.00
	TOTALS		532,329	0		
	G - PAIN MANAGEMENT MEDICAL DIRECTOR					
1.00	MEDICAL SPECIALITIES	190.02	0	48,060	0	1.00
	TOTALS		0	48,060		
500.00	Grand Total: Decreases		1,988,511	4,738,950		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/15/2023 9:14 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,900,662	0	0	0	0	1.00
2.00	Land Improvements	12,298,052	494,190	0	494,190	0	2.00
3.00	Buildings and Fixtures	142,690,117	4,426,868	0	4,426,868	0	3.00
4.00	Building Improvements	264,162	3,850	0	3,850	3,850	4.00
5.00	Fixed Equipment	5,846,210	1,120,595	0	1,120,595	0	5.00
6.00	Movable Equipment	59,275,973	5,318,966	0	5,318,966	3,586,757	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	223,275,176	11,364,469	0	11,364,469	3,590,607	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	223,275,176	11,364,469	0	11,364,469	3,590,607	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,900,662	0	1.00
2.00	Land Improvements	12,792,242	0	2.00
3.00	Buildings and Fixtures	147,116,985	0	3.00
4.00	Building Improvements	264,162	0	4.00
5.00	Fixed Equipment	6,966,805	0	5.00
6.00	Movable Equipment	61,008,182	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	231,049,038	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	231,049,038	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	17,099,936	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	17,099,936	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	17,099,936	1.00
3.00	Total (sum of lines 1-2)	0	17,099,936	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/15/2023 9:14 am

	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	163,999,203	0	163,999,203	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	163,999,203	0	163,999,203	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	17,084,936	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,084,936	0	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	-3,257,195	0	0	0	13,827,741	1.00
3.00	Total (sum of lines 1-2)	-3,257,195	0	0	0	13,827,741	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,257,195	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-3,787	ADMINISTRATIVE & GENERAL	5.00	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	-6,141,851			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	3,767,968			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-536,387	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-2,996	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	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MAJ OTHER REVENUES CASH OVER/SHORT	B	-8,237	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	MAJ OTHER REVENUES RENTAL INCOME	B	-15,000	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	MAJ TECHNOLOGY SERV CONTRACT LABOR	B	-255,312	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MAJ PATIENT ACCESS CONTRACT LABOR	B	-8,080	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MAJ ACCOUNTING CONTRACT LABOR	B	-120,684	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MAJ ADMINISTRATION CONTRACT LABOR	B	-250,560	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MH EDUCATION CLASS REVENUE	B	-17,750	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MAJ ACCOUNTING VENDOR REBATES	B	-40,590	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MAJ OTHER REVENUES PURCHASE DISCOUNT	B	-2,715	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	44.01
44.02	MAJ HUMAN RESOURCES OTHER INCOME	B	-335	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.02
44.03	MAJ CL NUTR-DIAB ED OTHER INCOME	B	-2,270	NURSING ADMINISTRATION	13.00	0	44.03
45.00	MAJ OTHER REVENUES REAPPOINTMENT FEE	B	-4,878	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MAJ PATIENT FINANCI PHYSICIAN BILLIN	B	-716,180	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MAJ ENVIRONMENTAL S OTHER INCOME	B	0	HOUSEKEEPING	9.00	0	45.02
45.03	MAJ FOOD AND NUTRIT OTHER CAFETERIA	B	0	CAFETERIA	11.00	0	45.03
45.04	MAJ PHARMACY VENDOR REBATES	B	0	PHARMACY	15.00	0	45.04
45.05	MAJ OTHER REVENUES XEROX AND COPYING	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MAJ INPATIENT-AMU OTHER INCOME	B	0	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	MAJ RESPIRATORY CAR VENDOR REBATES	B	0	RESPIRATORY THERAPY	65.00	0	45.07
45.08	MAJ REHABILATION SE CONTRACT LABOR	B	-66,120	PHYSICAL THERAPY	66.00	0	45.08
45.09	MAJ CARDIAC DISEASE CONTRACT LABOR	B	-57,384	ELECTROCARDIOLOGY	69.00	0	45.09
45.10	MAJ CENTRAL SUPPLY VENDOR REBATES	B	0	OPERATING ROOM	50.00	0	45.10
45.11	MH MHP FIM OTHER INCOME	B	-207	RURAL HEALTH CLINIC III	88.02	0	45.11
45.12	MAJ DISEASE MGT CLASS REVENUE	B	0	CLINIC	90.00	0	45.12
45.13	MAJ MEDICAL SPECIAL RENTAL INCOME	B	0	CLINIC	90.00	0	45.13
45.14	MAJ ONSITE SOLUTION OTHER INCOME	B	0	HOME HEALTH AGENCY	101.00	0	45.14
45.15	MAJ OTHER REVENUES OTHER INCOME	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	MAJ OTHER REVENUES OTHER INCOME	B	-63,688	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	MEALS ON WHEELS	A	-38,877	DIETARY	10.00	0	45.17
45.18	PROMOTIONAL GIFTS	A	-561	RESPIRATORY THERAPY	65.00	0	45.18
45.19	PROMOTIONAL GIFTS	A	-14,053	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	PROMOTIONAL GIFTS	A	0	NURSING ADMINISTRATION	13.00	0	45.20
45.21	PROMOTIONAL GIFTS	A	-2,290	ADULTS & PEDIATRICS	30.00	0	45.21
45.22	PROMOTIONAL GIFTS	A	-1,616	RADIOLOGY-DIAGNOSTIC	54.00	0	45.22
45.23	PROMOTIONAL GIFTS	A	-5,270	ONCOLOGY	56.01	0	45.23
45.24	PROMOTIONAL GIFTS	A	-12,550	PHYSICAL THERAPY	66.00	0	45.24
45.25	PROMOTIONAL GIFTS	A	-458	RURAL HEALTH CLINIC	88.00	0	45.25

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
45.26	PROMOTIONAL GIFTS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.26
45.27	PROMOTIONAL GIFTS	A	-1,438	CLINIC	90.00	0	45.27
45.28	PROMOTIONAL GIFTS	A	-1,643	ELECTROCARDIOLOGY	69.00	0	45.28
45.29	MAJ WOUND CARE ADVERTISING	A	0	CLINIC	90.00	0	45.29
45.30	MAJ BEE UNIQUE BOUT ADVERTISING	A	0	ONCOLOGY	56.01	0	45.30
45.31	MAJ MHP FIM ADVERTISING	A	0	RURAL HEALTH CLINIC III	88.02	0	45.31
45.32	MAJ COMMUNITY OUTRE ADVERTISING	A	-2,950	ADMINISTRATIVE & GENERAL	5.00	0	45.32
45.33	MAJ MARKETING ADVERTISING	A	-24,620	ADMINISTRATIVE & GENERAL	5.00	0	45.33
45.34	MAJ HUMAN RESOURCES ADVERTISING	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.34
45.35	MAJ ADMINISTRATION ADVERTISING	A	0	ADMINISTRATIVE & GENERAL	5.00	0	45.35
45.36	MAJ REHABILATION SE ADVERTISING-SPOR	A	0	PHYSICAL THERAPY	66.00	0	45.36
45.37	MAJ HUMAN RESOURCES ADVERTISING	A	0	RURAL HEALTH CLINIC II	88.01	0	45.37
45.38	COMMUNITY OUTREACH	A	-432,408	ADMINISTRATIVE & GENERAL	5.00	0	45.38
45.39	HAF EXPENSE	A	-5,927,722	ADMINISTRATIVE & GENERAL	5.00	0	45.39
45.40	NON-ALLOWABLE RHC	A	-22,932	RURAL HEALTH CLINIC II	88.01	0	45.40
45.41	LOBBYING % OF DUES	A	-12,189	ADMINISTRATIVE & GENERAL	5.00	0	45.41
45.42	MISC. PURCHASED SERVICES	A	-5,678,587	ADMINISTRATIVE & GENERAL	5.00	0	45.42
45.43	NON-ALLOWABLE RHC OFFSET	A	-225,262	RURAL HEALTH CLINIC II	88.01	0	45.43
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,209,664				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/15/2023 9:14 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	88.00	RURAL HEALTH CLINIC	MHP PEDS RHC	1,561,188	719,777	1.00
2.00	88.01	RURAL HEALTH CLINIC II	MHP OB/GYN RHC	813,140	607,337	2.00
3.00	88.02	RURAL HEALTH CLINIC III	MHP FAM PRACT RHC	5,860,261	3,139,507	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,234,589	4,466,621	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	MMG	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/15/2023 9:14 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	841,411	0	1.00
2.00	205,803	0	2.00
3.00	2,720,754	0	3.00
4.00	0	0	4.00
5.00	3,767,968		5.00

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

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

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

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

6.00	PHYSICIAN GROUP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2023 9:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	17,984	0	17,984	179,000	108	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	2,080	1,677	403	179,000	4	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,083	2,083	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	3,850,777	3,047,224	803,553	239,400	3,439	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	660,376	660,376	0	271,900	0	5.00
6.00	56.01	ONCOLOGY	257,118	232,118	25,000	271,900	150	6.00
7.00	57.00	CT SCAN	839,967	839,967	0	0	0	7.00
8.00	60.00	LABORATORY	153,550	18,081	135,469	260,300	169	8.00
9.00	91.00	EMERGENCY	847,500	785,000	62,500	179,000	504	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,631,435	5,586,526	1,044,909		4,374	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	9,294	465	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	344	17	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	395,816	19,791	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.01	ONCOLOGY	19,608	980	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	21,149	1,057	0	0	0	8.00
9.00	91.00	EMERGENCY	43,373	2,169	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			489,584	24,479	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	9,294	8,690	8,690		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	344	59	1,736		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,083		3.00
4.00	53.00	ANESTHESIOLOGY	0	395,816	407,737	3,454,961		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	660,376		5.00
6.00	56.01	ONCOLOGY	0	19,608	5,392	237,510		6.00
7.00	57.00	CT SCAN	0	0	0	839,967		7.00
8.00	60.00	LABORATORY	0	21,149	114,320	132,401		8.00
9.00	91.00	EMERGENCY	0	43,373	19,127	804,127		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	489,584	555,325	6,141,851		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	13,827,741	13,827,741				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,069,911	43,825	12,113,736			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,137,914	915,177	1,896,531	21,949,622	21,949,622	5.00
7.00	00700	OPERATION OF PLANT	3,882,460	581,050	286,152	4,749,662	806,915	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	399,163	49,430	23,551	472,144	80,212	8.00
9.00	00900	HOUSEKEEPING	2,883,742	113,430	352,464	3,349,636	569,066	9.00
10.00	01000	DIETARY	484,983	55,221	43,706	583,910	99,200	10.00
11.00	01100	CAFETERIA	1,591,508	219,202	173,520	1,984,230	337,099	11.00
13.00	01300	NURSING ADMINISTRATION	1,239,547	97,402	156,464	1,493,413	253,714	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	120,940	0	120,940	20,546	14.00
15.00	01500	PHARMACY	15,677,948	100,503	245,472	16,023,923	2,722,288	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,023,143	83,504	291,151	2,397,798	407,360	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,456,729	947,158	1,326,250	10,730,137	1,822,932	30.00
31.00	03100	INTENSIVE CARE UNIT	2,891,726	186,435	423,003	3,501,164	594,809	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,192,982	1,045,793	577,561	7,816,336	1,327,910	50.00
53.00	05300	ANESTHESIOLOGY	205,505	18,718	147,059	371,282	63,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,943,110	333,005	651,168	5,927,283	1,006,980	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	2,355,891	744,770	300,851	3,401,512	577,879	56.01
57.00	05700	CT SCAN	1,331,837	55,333	111,658	1,498,828	254,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	878,826	56,005	104,924	1,039,755	176,643	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,862,401	214,980	457,039	7,534,420	1,280,015	60.00
65.00	06500	RESPIRATORY THERAPY	1,954,982	172,088	319,710	2,446,780	415,681	65.00
65.01	06501	SLEEP LAB	595,895	0	86,655	682,550	115,958	65.01
66.00	06600	PHYSICAL THERAPY	2,378,964	441,130	419,458	3,239,552	550,364	66.00
69.00	06900	ELECTROCARDIOLOGY	2,000,076	142,087	130,862	2,273,025	386,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,975,481	0	22,279	2,997,760	509,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,665,399	273,488	282,521	4,221,408	717,171	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,973,452	161,590	140,631	2,275,673	386,612	88.01
88.02	08802	RURAL HEALTH CLINIC III	14,376,461	901,577	1,197,307	16,475,345	2,799,031	88.02
90.00	09000	CLINIC	2,098,122	102,222	280,153	2,480,497	421,409	90.00
91.00	09100	EMERGENCY	4,591,994	489,103	658,836	5,739,933	975,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,867,252	274,796	292,171	2,434,219	413,547	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,815,145	8,939,962	11,399,107	140,212,737	20,091,651	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,059	0	28,059	4,767	190.00
190.01	19001	UROLOGY	48,484	0	1,375	49,859	8,470	190.01
190.02	19002	MEDICAL SPECIALITIES	851,379	259,702	37,235	1,148,316	195,086	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	245,409	20,549	20,644	286,602	48,691	190.05
190.06	19006	YMCA/WELLNESS CENTER	44,162	2,962,190	1,800	3,008,152	511,052	190.06
190.07	19007	I-74 CAMPUS	610	0	0	610	104	190.07
190.08	19008	RAMPART	139,416	411,092	14,704	565,212	96,023	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	21,746	356,842	7	378,595	64,319	190.09
190.11	19011	MHP ADMIN BUILDING	96,107	11,209	8,624	115,940	19,697	190.11
190.16	19016	RENOVO	97,899	407,804	9,193	514,896	87,475	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,476,368	8,369	578,213	4,062,950	690,251	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	6,966	93,404	0	100,370	17,052	192.02
194.00	07950	UNAVIE	305,428	328,559	42,834	676,821	114,984	194.00
200.00		Cross Foot Adjustments				0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0097

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

Worksheet B Part I Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	151,149,119	13,827,741	12,113,736	151,149,119	21,949,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,556,577					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,352	574,708				8.00
9.00	00900	HOUSEKEEPING	51,294	0	3,969,996			9.00
10.00	01000	DIETARY	24,971	0	18,081	726,162		10.00
11.00	01100	CAFETERIA	99,124	0	71,772	0	2,492,225	11.00
13.00	01300	NURSING ADMINISTRATION	44,046	0	31,892	0	38,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,690	0	39,599	0	0	14.00
15.00	01500	PHARMACY	45,448	0	32,907	0	52,204	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,761	0	27,341	0	111,392	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	428,311	223,043	310,125	592,012	357,808	30.00
31.00	03100	INTENSIVE CARE UNIT	84,307	0	61,044	134,150	118,397	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472,915	56,764	342,421	0	160,648	50.00
53.00	05300	ANESTHESIOLOGY	8,465	0	6,129	0	38,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,587	100,890	109,035	0	170,523	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	336,790	36,076	243,858	0	78,121	56.01
57.00	05700	CT SCAN	25,022	0	18,117	0	26,174	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,326	0	18,338	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	97,215	0	70,390	0	154,814	60.00
65.00	06500	RESPIRATORY THERAPY	77,820	14,344	56,346	0	84,098	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	199,482	18,248	144,438	0	99,315	66.00
69.00	06900	ELECTROCARDIOLOGY	64,253	0	46,523	0	30,649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	10,630	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	123,673	0	89,547	0	104,819	88.00
88.01	08801	RURAL HEALTH CLINIC II	73,072	0	52,909	0	53,167	88.01
88.02	08802	RURAL HEALTH CLINIC III	407,699	0	295,201	0	402,940	88.02
90.00	09000	CLINIC	46,225	0	33,470	0	57,283	90.00
91.00	09100	EMERGENCY	221,176	125,343	160,146	0	183,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	124,265	0	89,976	0	74,750	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,346,289	574,708	2,369,605	726,162	2,407,935	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,688	0	9,187	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	117,439	0	85,033	0	16,604	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	9,292	0	6,728	0	5,701	190.05
190.06	19006	YMCA/WELLNESS CENTER	1,339,523	0	969,903	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	185,898	0	134,602	0	8,196	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	161,367	0	116,840	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	5,069	0	3,670	0	0	190.11
190.16	19016	RENOVO	184,412	0	133,526	0	4,507	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,785	0	2,740	0	49,282	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	42,238	0	30,583	0	0	192.02
194.00	07950	UNAVIE	148,577	0	107,579	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)	5,556,577	574,708	3,969,996	726,162	2,492,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	1,861,547					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	235,775				14.00
15.00	01500	PHARMACY	0	0	18,876,770			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,981,652		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	352,656	0	0	101,024	14,918,048	30.00
31.00	03100	INTENSIVE CARE UNIT	116,692	0	0	36,255	4,646,818	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,335	129,676	0	509,057	10,974,062	50.00
53.00	05300	ANESTHESIOLOGY	38,134	0	0	4,029	529,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	205,941	7,671,239	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	76,996	0	0	149,379	4,900,611	56.01
57.00	05700	CT SCAN	0	0	0	190,177	2,012,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	64,743	1,324,805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	320,189	9,457,043	60.00
65.00	06500	RESPIRATORY THERAPY	82,888	0	0	71,449	3,249,406	65.00
65.01	06501	SLEEP LAB	25,331	0	0	18,733	842,572	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	55,961	4,307,360	66.00
69.00	06900	ELECTROCARDIOLOGY	30,207	0	0	106,161	2,936,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	106,099	0	73,360	3,697,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,876,770	398,038	19,274,808	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,309	0	0	27,186	5,387,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	52,401	0	0	15,004	2,908,838	88.01
88.02	08802	RURAL HEALTH CLINIC III	397,141	0	0	109,449	20,886,806	88.02
90.00	09000	CLINIC	56,458	0	0	37,321	3,132,663	90.00
91.00	09100	EMERGENCY	180,394	0	0	430,449	8,015,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	73,674	0	0	57,747	3,268,178	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,744,616	235,775	18,876,770	2,981,652	134,342,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	54,701	190.00
190.01	19001	UROLOGY	0	0	0	0	58,329	190.01
190.02	19002	MEDICAL SPECIALITIES	0	0	0	0	1,562,478	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	0	357,014	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0	0	5,828,630	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	714	190.07
190.08	19008	RAMPART	8,078	0	0	0	998,009	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	721,121	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	144,376	190.11
190.16	19016	RENOVO	4,442	0	0	0	929,258	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	48,572	0	0	0	4,857,580	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0	0	190,243	192.02
194.00	07950	UNAVIE	55,839	0	0	0	1,103,800	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,861,547	235,775	18,876,770	2,981,652	151,149,119	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	14,918,048	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,646,818	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	10,974,062	50.00
53.00	05300	ANESTHESIOLOGY	0	529,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,671,239	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	4,900,611	56.01
57.00	05700	CT SCAN	0	2,012,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,324,805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	9,457,043	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,249,406	65.00
65.01	06501	SLEEP LAB	0	842,572	65.01
66.00	06600	PHYSICAL THERAPY	0	4,307,360	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,936,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,697,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,274,808	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	5,387,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,908,838	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	20,886,806	88.02
90.00	09000	CLINIC	0	3,132,663	90.00
91.00	09100	EMERGENCY	0	8,015,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	3,268,178	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	134,342,866	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,701	190.00
190.01	19001	UROLOGY	0	58,329	190.01
190.02	19002	MEDICAL SPECIALITIES	0	1,562,478	190.02
190.03	19003	UNUSED	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	190.04
190.05	19005	MARKETING	0	357,014	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	5,828,630	190.06
190.07	19007	I-74 CAMPUS	0	714	190.07
190.08	19008	RAMPART	0	998,009	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	721,121	190.09
190.11	19011	MHP ADMIN BUILDING	0	144,376	190.11
190.16	19016	RENOVO	0	929,258	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	4,857,580	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	190,243	192.02
194.00	07950	UNAVIE	0	1,103,800	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	151,149,119	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	43,825	43,825	43,825		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	915,177	915,177	6,839	922,016	5.00
7.00	00700	OPERATION OF PLANT	0	581,050	581,050	1,036	33,894	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,430	49,430	85	3,369	8.00
9.00	00900	HOUSEKEEPING	0	113,430	113,430	1,276	23,903	9.00
10.00	01000	DIETARY	0	55,221	55,221	158	4,167	10.00
11.00	01100	CAFETERIA	0	219,202	219,202	628	14,159	11.00
13.00	01300	NURSING ADMINISTRATION	0	97,402	97,402	566	10,657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	120,940	120,940	0	863	14.00
15.00	01500	PHARMACY	0	100,503	100,503	889	114,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	83,504	83,504	1,054	17,111	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	947,158	947,158	4,801	76,570	30.00
31.00	03100	INTENSIVE CARE UNIT	0	186,435	186,435	1,531	24,984	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,045,793	1,045,793	2,091	55,777	50.00
53.00	05300	ANESTHESIOLOGY	0	18,718	18,718	532	2,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333,005	333,005	2,357	42,297	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	744,770	744,770	1,089	24,273	56.01
57.00	05700	CT SCAN	0	55,333	55,333	404	10,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	56,005	56,005	380	7,420	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	214,980	214,980	1,655	53,766	60.00
65.00	06500	RESPIRATORY THERAPY	0	172,088	172,088	1,157	17,460	65.00
65.01	06501	SLEEP LAB	0	0	0	314	4,871	65.01
66.00	06600	PHYSICAL THERAPY	0	441,130	441,130	1,518	23,117	66.00
69.00	06900	ELECTROCARDIOLOGY	0	142,087	142,087	474	16,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	81	21,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	273,488	273,488	1,023	30,124	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,590	161,590	509	16,239	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	901,577	901,577	4,334	117,619	88.02
90.00	09000	CLINIC	0	102,222	102,222	1,014	17,701	90.00
91.00	09100	EMERGENCY	0	489,103	489,103	2,385	40,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	274,796	274,796	1,058	17,371	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,939,962	8,939,962	41,238	843,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,059	28,059	0	200	190.00
190.01	19001	UROLOGY	0	0	0	5	356	190.01
190.02	19002	MEDICAL SPECIALITIES	0	259,702	259,702	135	8,194	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	20,549	20,549	75	2,045	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	2,962,190	2,962,190	7	21,466	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	4	190.07
190.08	19008	RAMPART	0	411,092	411,092	53	4,033	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	356,842	356,842	0	2,702	190.09
190.11	19011	MHP ADMIN BUILDING	0	11,209	11,209	31	827	190.11
190.16	19016	RENOVO	0	407,804	407,804	33	3,674	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	8,369	8,369	2,093	28,993	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	93,404	93,404	0	716	192.02
194.00	07950	UNAVIE	0	328,559	328,559	155	4,830	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4.00	5.00	
202.00	TOTAL (sum lines 118 through 201)	0	13,827,741	13,827,741	43,825	922,016	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	615,980					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,478	55,362				8.00
9.00	00900	HOUSEKEEPING	5,686	0	144,295			9.00
10.00	01000	DIETARY	2,768	0	657	62,971		10.00
11.00	01100	CAFETERIA	10,989	0	2,609	0	247,587	11.00
13.00	01300	NURSING ADMINISTRATION	4,883	0	1,159	0	3,823	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,063	0	1,439	0	0	14.00
15.00	01500	PHARMACY	5,038	0	1,196	0	5,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,186	0	994	0	11,066	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,481	21,486	11,272	51,338	35,546	30.00
31.00	03100	INTENSIVE CARE UNIT	9,346	0	2,219	11,633	11,762	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,425	5,468	12,446	0	15,959	50.00
53.00	05300	ANESTHESIOLOGY	938	0	223	0	3,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,694	9,719	3,963	0	16,940	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	37,335	3,475	8,863	0	7,761	56.01
57.00	05700	CT SCAN	2,774	0	659	0	2,600	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,808	0	667	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,777	0	2,558	0	15,380	60.00
65.00	06500	RESPIRATORY THERAPY	8,627	1,382	2,048	0	8,355	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	22,114	1,758	5,250	0	9,866	66.00
69.00	06900	ELECTROCARDIOLOGY	7,123	0	1,691	0	3,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,710	0	3,255	0	10,413	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,100	0	1,923	0	5,282	88.01
88.02	08802	RURAL HEALTH CLINIC III	45,196	0	10,729	0	40,029	88.02
90.00	09000	CLINIC	5,124	0	1,217	0	5,691	90.00
91.00	09100	EMERGENCY	24,519	12,074	5,821	0	18,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	13,775	0	3,270	0	7,426	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	370,957	55,362	86,128	62,971	239,213	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,407	0	334	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	13,019	0	3,091	0	1,650	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	1,030	0	245	0	566	190.05
190.06	19006	YMCA/WELLNESS CENTER	148,493	0	35,250	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	20,608	0	4,892	0	814	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	17,888	0	4,247	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	562	0	133	0	0	190.11
190.16	19016	RENOVO	20,443	0	4,853	0	448	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	420	0	100	0	4,896	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	4,682	0	1,112	0	0	192.02
194.00	07950	UNAVIE	16,471	0	3,910	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)	615,980	55,362	144,295	62,971	247,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	118,490					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	129,305				14.00
15.00	01500	PHARMACY	0	0	227,159			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	117,915		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,447	0	0	3,990	1,222,089	30.00
31.00	03100	INTENSIVE CARE UNIT	7,428	0	0	1,432	256,770	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,078	71,118	0	20,252	1,291,407	50.00
53.00	05300	ANESTHESIOLOGY	2,427	0	0	159	29,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,134	433,109	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	4,901	0	0	5,900	838,367	56.01
57.00	05700	CT SCAN	0	0	0	7,512	79,978	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,557	69,837	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	12,647	311,763	60.00
65.00	06500	RESPIRATORY THERAPY	5,276	0	0	2,822	219,215	65.00
65.01	06501	SLEEP LAB	1,612	0	0	740	7,537	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	2,210	506,963	66.00
69.00	06900	ELECTROCARDIOLOGY	1,923	0	0	4,193	176,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	58,187	0	2,898	83,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	227,159	15,722	242,881	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,576	0	0	1,074	339,663	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,335	0	0	593	197,571	88.01
88.02	08802	RURAL HEALTH CLINIC III	25,279	0	0	4,323	1,149,086	88.02
90.00	09000	CLINIC	3,594	0	0	1,474	138,037	90.00
91.00	09100	EMERGENCY	11,482	0	0	17,002	621,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,689	0	0	2,281	324,666	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,047	129,305	227,159	117,915	8,540,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	30,000	190.00
190.01	19001	UROLOGY	0	0	0	0	361	190.01
190.02	19002	MEDICAL SPECIALITIES	0	0	0	0	285,791	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	0	24,510	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0	0	3,167,406	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	4	190.07
190.08	19008	RAMPART	514	0	0	0	442,006	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	381,679	190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0	0	12,762	190.11
190.16	19016	RENOVO	283	0	0	0	437,538	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,092	0	0	0	47,963	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0	0	99,914	192.02
194.00	07950	UNAVIE	3,554	0	0	0	357,479	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	118,490	129,305	227,159	117,915	13,827,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,222,089	30.00
31.00	03100	INTENSIVE CARE UNIT	0	256,770	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,291,407	50.00
53.00	05300	ANESTHESIOLOGY	0	29,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	433,109	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	838,367	56.01
57.00	05700	CT SCAN	0	79,978	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	69,837	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	311,763	60.00
65.00	06500	RESPIRATORY THERAPY	0	219,215	65.00
65.01	06501	SLEEP LAB	0	7,537	65.01
66.00	06600	PHYSICAL THERAPY	0	506,963	66.00
69.00	06900	ELECTROCARDIOLOGY	0	176,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	83,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	242,881	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	339,663	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	197,571	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,149,086	88.02
90.00	09000	CLINIC	0	138,037	90.00
91.00	09100	EMERGENCY	0	621,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	324,666	92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,540,328	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,000	190.00
190.01	19001	UROLOGY	0	361	190.01
190.02	19002	MEDICAL SPECIALITIES	0	285,791	190.02
190.03	19003	UNUSED	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	190.04
190.05	19005	MARKETING	0	24,510	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	3,167,406	190.06
190.07	19007	I-74 CAMPUS	0	4	190.07
190.08	19008	RAMPART	0	442,006	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	381,679	190.09
190.11	19011	MHP ADMIN BUILDING	0	12,762	190.11
190.16	19016	RENOVO	0	437,538	190.16
190.17	19017	IMA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	47,963	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	99,914	192.02
194.00	07950	UNAVIE	0	357,479	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,827,741	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	370,104					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,173	63,007,030				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,495	9,864,384	-21,949,622	129,199,497		5.00
7.00	00700	OPERATION OF PLANT	15,552	1,488,358	0	4,749,662	328,884	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,323	122,496	0	472,144	1,323	8.00
9.00	00900	HOUSEKEEPING	3,036	1,833,269	0	3,349,636	3,036	9.00
10.00	01000	DIETARY	1,478	227,327	0	583,910	1,478	10.00
11.00	01100	CAFETERIA	5,867	902,528	0	1,984,230	5,867	11.00
13.00	01300	NURSING ADMINISTRATION	2,607	813,815	0	1,493,413	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	0	0	120,940	3,237	14.00
15.00	01500	PHARMACY	2,690	1,276,773	0	16,023,923	2,690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	1,514,360	0	2,397,798	2,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,351	6,898,213	0	10,730,137	25,351	30.00
31.00	03100	INTENSIVE CARE UNIT	4,990	2,200,163	0	3,501,164	4,990	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,991	3,004,063	0	7,816,336	27,991	50.00
53.00	05300	ANESTHESIOLOGY	501	764,896	0	371,282	501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,913	3,386,915	0	5,927,283	8,913	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	19,934	1,564,815	0	3,401,512	19,934	56.01
57.00	05700	CT SCAN	1,481	580,764	0	1,498,828	1,481	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,499	545,738	0	1,039,755	1,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,754	2,377,193	0	7,534,420	5,754	60.00
65.00	06500	RESPIRATORY THERAPY	4,606	1,662,902	0	2,446,780	4,606	65.00
65.01	06501	SLEEP LAB	0	450,717	0	682,550	0	65.01
66.00	06600	PHYSICAL THERAPY	11,807	2,181,724	0	3,239,552	11,807	66.00
69.00	06900	ELECTROCARDIOLOGY	3,803	680,650	0	2,273,025	3,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	115,878	0	2,997,760	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,320	1,469,473	0	4,221,408	7,320	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,325	731,464	0	2,275,673	4,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,131	6,227,540	0	16,475,345	24,131	88.02
90.00	09000	CLINIC	2,736	1,457,156	0	2,480,497	2,736	90.00
91.00	09100	EMERGENCY	13,091	3,426,798	0	5,739,933	13,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,355	1,519,665	0	2,434,219	7,355	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	239,281	59,290,037	-21,949,622	118,263,115	198,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0	0	28,059	751	190.00
190.01	19001	UROLOGY	0	7,150	0	49,859	0	190.01
190.02	19002	MEDICAL SPECIALITIES	6,951	193,672	0	1,148,316	6,951	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	550	107,376	0	286,602	550	190.05
190.06	19006	YMCA/WELLNESS CENTER	79,284	9,361	0	3,008,152	79,284	190.06
190.07	19007	I-74 CAMPUS	0	0	0	610	0	190.07
190.08	19008	RAMPART	11,003	76,479	0	565,212	11,003	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	9,551	34	0	378,595	9,551	190.09
190.11	19011	MHP ADMIN BUILDING	300	44,857	0	115,940	300	190.11
190.16	19016	RENOVO	10,915	47,814	0	514,896	10,915	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	224	3,007,456	0	4,062,950	224	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	2,500	0	0	100,370	2,500	192.02
194.00	07950	UNAVIE	8,794	222,794	0	676,821	8,794	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	13,827,741	12,113,736		21,949,622	5,556,577	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	37.361771	0.192260		0.169889	16.895249	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		43,825		922,016	615,980	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000696		0.007136	1.872940	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	412,534					8.00
9.00	00900	HOUSEKEEPING	0	324,525				9.00
10.00	01000	DIETARY	0	1,478	9,776			10.00
11.00	01100	CAFETERIA	0	5,867	0	1,250,314		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,607	0	19,306	947,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,237	0	0	0	14.00
15.00	01500	PHARMACY	0	2,690	0	26,190	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,235	0	55,884	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	160,104	25,351	7,970	179,507	179,507	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,990	1,806	59,398	59,398	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,746	27,991	0	80,595	80,595	50.00
53.00	05300	ANESTHESIOLOGY	0	501	0	19,411	19,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,420	8,913	0	85,549	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	25,896	19,934	0	39,192	39,192	56.01
57.00	05700	CT SCAN	0	1,481	0	13,131	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,499	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,754	0	77,668	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,296	4,606	0	42,191	42,191	65.00
65.01	06501	SLEEP LAB	0	0	0	0	12,894	65.01
66.00	06600	PHYSICAL THERAPY	13,099	11,807	0	49,825	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,803	0	15,376	15,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,333	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,320	0	52,586	52,586	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,325	0	26,673	26,673	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	24,131	0	202,150	202,150	88.02
90.00	09000	CLINIC	0	2,736	0	28,738	28,738	90.00
91.00	09100	EMERGENCY	89,973	13,091	0	91,823	91,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,355	0	37,501	37,501	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,534	193,702	9,776	1,208,027	888,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	0	0	190.00
190.01	19001	UROLOGY	0	0	0	0	0	190.01
190.02	19002	MEDICAL SPECIALITIES	0	6,951	0	8,330	0	190.02
190.03	19003	UNUSED	0	0	0	0	0	190.03
190.04	19004	FOR FUTURE USE	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	550	0	2,860	0	190.05
190.06	19006	YMCA/WELLNESS CENTER	0	79,284	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	0	0	190.07
190.08	19008	RAMPART	0	11,003	0	4,112	4,112	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	9,551	0	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	0	300	0	0	0	190.11
190.16	19016	RENOVO	0	10,915	0	2,261	2,261	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	224	0	24,724	24,724	192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	2,500	0	0	0	192.02
194.00	07950	UNAVIE	0	8,794	0	0	28,423	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)	574,708	3,969,996	726,162	2,492,225	1,861,547	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	1.393117	12.233252	74.280074	1.993279	1.964579	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,362	144,295	62,971	247,587	118,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.134200	0.444634	6.441387	0.198020	0.125048	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/15/2023 9:14 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	518,818,781		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	17,578,499		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,308,551		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	55	0	88,578,148		50.00
53.00	05300	ANESTHESIOLOGY	0	0	701,009		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	35,834,506		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	ONCOLOGY	0	0	25,992,557		56.01
57.00	05700	CT SCAN	0	0	33,091,503		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	11,265,466		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	55,714,055		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	12,432,327		65.00
65.01	06501	SLEEP LAB	0	0	3,259,574		65.01
66.00	06600	PHYSICAL THERAPY	0	0	9,737,509		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,472,369		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45	0	12,764,930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	69,260,051		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	4,730,452		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,610,700		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	19,044,558		88.02
90.00	09000	CLINIC	0	0	6,494,038		90.00
91.00	09100	EMERGENCY	0	0	74,899,788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	10,048,191		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	518,818,781		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	UROLOGY	0	0	0		190.01
190.02	19002	MEDICAL SPECIALITIES	0	0	0		190.02
190.03	19003	UNUSED	0	0	0		190.03
190.04	19004	FOR FUTURE USE	0	0	0		190.04
190.05	19005	MARKETING	0	0	0		190.05
190.06	19006	YMCA/WELLNESS CENTER	0	0	0		190.06
190.07	19007	I-74 CAMPUS	0	0	0		190.07
190.08	19008	RAMPART	0	0	0		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0		190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0		190.11
190.16	19016	RENOVO	0	0	0		190.16
190.17	19017	IMA	0	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0	0		190.18
190.19	19019	MHCD	0	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	HOSPITALIST	0	0	0		192.01
192.02	19202	PSYCHIATRIC OUTPATIENT	0	0	0		192.02
194.00	07950	UNAVIE	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	235,775	18,876,770	2,981,652	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2,357.750000	188,767.700000	0.005747	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	129,305	227,159	117,915	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,293.050000	2,271.590000	0.000227	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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		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	14,918,048		14,918,048	0	14,918,048	30.00
31.00	03100	INTENSIVE CARE UNIT	4,646,818		4,646,818	0	4,646,818	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,974,062		10,974,062	0	10,974,062	50.00
53.00	05300	ANESTHESIOLOGY	529,808		529,808	407,737	937,545	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,671,239		7,671,239	0	7,671,239	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	4,900,611		4,900,611	5,392	4,906,003	56.01
57.00	05700	CT SCAN	2,012,952		2,012,952	0	2,012,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,324,805		1,324,805	0	1,324,805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,457,043		9,457,043	114,320	9,571,363	60.00
65.00	06500	RESPIRATORY THERAPY	3,249,406	0	3,249,406	0	3,249,406	65.00
65.01	06501	SLEEP LAB	842,572	0	842,572	0	842,572	65.01
66.00	06600	PHYSICAL THERAPY	4,307,360	0	4,307,360	0	4,307,360	66.00
69.00	06900	ELECTROCARDIOLOGY	2,936,980		2,936,980	0	2,936,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,697,135		3,697,135	0	3,697,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,274,808		19,274,808	0	19,274,808	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,387,113		5,387,113	0	5,387,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,908,838		2,908,838	0	2,908,838	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,886,806		20,886,806	0	20,886,806	88.02
90.00	09000	CLINIC	3,132,663		3,132,663	0	3,132,663	90.00
91.00	09100	EMERGENCY	8,015,621		8,015,621	19,127	8,034,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,158,341		2,158,341		2,158,341	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,268,178		3,268,178	0	3,268,178	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,501,207	0	136,501,207	546,576	137,047,783	200.00
201.00		Less Observation Beds	2,158,341		2,158,341		2,158,341	201.00
202.00		Total (see instructions)	134,342,866	0	134,342,866	546,576	134,889,442	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		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	15,458,869		15,458,869			30.00
31.00	03100	INTENSIVE CARE UNIT	6,308,551		6,308,551			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,072,482	76,505,666	88,578,148	0.123891	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	701,009	701,009	0.755779	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964,016	32,870,490	35,834,506	0.214074	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	225,529	25,767,028	25,992,557	0.188539	0.000000	56.01
57.00	05700	CT SCAN	5,263,062	27,828,441	33,091,503	0.060830	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	800,142	10,465,324	11,265,466	0.117599	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,778,754	46,935,301	55,714,055	0.169743	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,386,904	2,045,423	12,432,327	0.261367	0.000000	65.00
65.01	06501	SLEEP LAB	979	3,258,595	3,259,574	0.258491	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,354,993	8,382,516	9,737,509	0.442347	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,538,001	15,934,368	18,472,369	0.158993	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,180,370	10,584,560	12,764,930	0.289632	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,543,644	57,716,407	69,260,051	0.278296	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,730,452	4,730,452			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,610,700	2,610,700			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	19,044,558	19,044,558			88.02
90.00	09000	CLINIC	15,682	6,478,356	6,494,038	0.482391	0.000000	90.00
91.00	09100	EMERGENCY	11,364,095	63,535,693	74,899,788	0.107018	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,522	2,091,108	2,119,630	1.018263	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,381,043	8,667,148	10,048,191	0.325250	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,665,638	426,153,143	518,818,781			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	92,665,638	426,153,143	518,818,781			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.123891	50.00
53.00	05300	ANESTHESIOLOGY	1.337422	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214074	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05601	ONCOLOGY	0.188746	56.01
57.00	05700	CT SCAN	0.060830	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117599	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.171794	60.00
65.00	06500	RESPIRATORY THERAPY	0.261367	65.00
65.01	06501	SLEEP LAB	0.258491	65.01
66.00	06600	PHYSICAL THERAPY	0.442347	66.00
69.00	06900	ELECTROCARDIOLOGY	0.158993	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.289632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278296	73.00
		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
90.00	09000	CLINIC	0.482391	90.00
91.00	09100	EMERGENCY	0.107273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.018263	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.325250	92.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/15/2023 9:14 am

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	14,918,048		14,918,048	0	14,918,048	30.00
31.00	03100	INTENSIVE CARE UNIT	4,646,818		4,646,818	0	4,646,818	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,974,062		10,974,062	0	10,974,062	50.00
53.00	05300	ANESTHESIOLOGY	529,808		529,808	407,737	937,545	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,671,239		7,671,239	0	7,671,239	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	4,900,611		4,900,611	5,392	4,906,003	56.01
57.00	05700	CT SCAN	2,012,952		2,012,952	0	2,012,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,324,805		1,324,805	0	1,324,805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,457,043		9,457,043	114,320	9,571,363	60.00
65.00	06500	RESPIRATORY THERAPY	3,249,406	0	3,249,406	0	3,249,406	65.00
65.01	06501	SLEEP LAB	842,572	0	842,572	0	842,572	65.01
66.00	06600	PHYSICAL THERAPY	4,307,360	0	4,307,360	0	4,307,360	66.00
69.00	06900	ELECTROCARDIOLOGY	2,936,980		2,936,980	0	2,936,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,697,135		3,697,135	0	3,697,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,274,808		19,274,808	0	19,274,808	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,387,113		5,387,113	0	5,387,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,908,838		2,908,838	0	2,908,838	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,886,806		20,886,806	0	20,886,806	88.02
90.00	09000	CLINIC	3,132,663		3,132,663	0	3,132,663	90.00
91.00	09100	EMERGENCY	8,015,621		8,015,621	19,127	8,034,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,158,341		2,158,341		2,158,341	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,268,178		3,268,178	0	3,268,178	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,501,207	0	136,501,207	546,576	137,047,783	200.00
201.00		Less Observation Beds	2,158,341		2,158,341		2,158,341	201.00
202.00		Total (see instructions)	134,342,866	0	134,342,866	546,576	134,889,442	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/15/2023 9:14 am

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	15,458,869		15,458,869			30.00
31.00	03100	INTENSIVE CARE UNIT	6,308,551		6,308,551			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,072,482	76,505,666	88,578,148	0.123891	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	701,009	701,009	0.755779	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964,016	32,870,490	35,834,506	0.214074	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	225,529	25,767,028	25,992,557	0.188539	0.000000	56.01
57.00	05700	CT SCAN	5,263,062	27,828,441	33,091,503	0.060830	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	800,142	10,465,324	11,265,466	0.117599	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,778,754	46,935,301	55,714,055	0.169743	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,386,904	2,045,423	12,432,327	0.261367	0.000000	65.00
65.01	06501	SLEEP LAB	979	3,258,595	3,259,574	0.258491	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,354,993	8,382,516	9,737,509	0.442347	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,538,001	15,934,368	18,472,369	0.158993	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,180,370	10,584,560	12,764,930	0.289632	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,543,644	57,716,407	69,260,051	0.278296	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,730,452	4,730,452	1.138816	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,610,700	2,610,700	1.114198	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	19,044,558	19,044,558	1.096734	0.000000	88.02
90.00	09000	CLINIC	15,682	6,478,356	6,494,038	0.482391	0.000000	90.00
91.00	09100	EMERGENCY	11,364,095	63,535,693	74,899,788	0.107018	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,522	2,091,108	2,119,630	1.018263	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,381,043	8,667,148	10,048,191	0.325250	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,665,638	426,153,143	518,818,781			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	92,665,638	426,153,143	518,818,781			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/15/2023 9:14 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05601	ONCOLOGY	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	06501	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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 PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,222,089	0	1,222,089	9,248	132.15	30.00
31.00	INTENSIVE CARE UNIT	256,770		256,770	1,806	142.18	31.00
200.00	Total (lines 30 through 199)	1,478,859		1,478,859	11,054		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,463	325,485	30.00
31.00	INTENSIVE CARE UNIT	387	55,024	31.00
200.00	Total (lines 30 through 199)	2,850	380,509	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,291,407	88,578,148	0.014579	2,257,000	32,905	50.00
53.00	05300	ANESTHESIOLOGY	29,490	701,009	0.042068	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,109	35,834,506	0.012086	978,852	11,830	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	838,367	25,992,557	0.032254	80,683	2,602	56.01
57.00	05700	CT SCAN	79,978	33,091,503	0.002417	1,824,264	4,409	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69,837	11,265,466	0.006199	302,802	1,877	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	311,763	55,714,055	0.005596	2,632,115	14,729	60.00
65.00	06500	RESPIRATORY THERAPY	219,215	12,432,327	0.017633	2,689,977	47,432	65.00
65.01	06501	SLEEP LAB	7,537	3,259,574	0.002312	0	0	65.01
66.00	06600	PHYSICAL THERAPY	506,963	9,737,509	0.052063	483,573	25,176	66.00
69.00	06900	ELECTROCARDIOLOGY	176,756	18,472,369	0.009569	893,660	8,551	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,614	12,764,930	0.006550	643,766	4,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	242,881	69,260,051	0.003507	3,078,679	10,797	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	339,663	4,730,452	0.071803	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	197,571	2,610,700	0.075677	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,149,086	19,044,558	0.060337	0	0	88.02
90.00	09000	CLINIC	138,037	6,494,038	0.021256	1,935	41	90.00
91.00	09100	EMERGENCY	621,529	74,899,788	0.008298	3,542,652	29,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,811	2,119,630	0.083416	5,083	424	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	324,666	10,048,191	0.032311	361,915	11,694	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,238,280	497,051,361		19,776,956	206,081	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III | Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,248	0.00	2,463	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,806	0.00	387	31.00
200.00		Total (lines 30 through 199)		0	11,054		2,850	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/15/2023 9:14 am

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		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	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
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/15/2023 9:14 am

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		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	88,578,148	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	701,009	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,834,506	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	0	0	0	25,992,557	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	33,091,503	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,265,466	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	55,714,055	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,432,327	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,259,574	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,737,509	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,472,369	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,764,930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,260,051	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,730,452	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,610,700	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	19,044,558	0.000000	88.02
90.00	09000	CLINIC	0	0	0	6,494,038	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	74,899,788	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,119,630	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	10,048,191	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	497,051,361		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/15/2023 9:14 am

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		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	2,257,000	0	12,571,924	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	978,852	0	5,432,448	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.000000	80,683	0	6,411,814	0	56.01
57.00	05700	CT SCAN	0.000000	1,824,264	0	5,246,522	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	302,802	0	2,276,258	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	2,632,115	0	3,308,775	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,689,977	0	421,480	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	577,596	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	483,573	0	45,978	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	893,660	0	3,737,272	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	643,766	0	2,590,760	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,078,679	0	18,488,626	0	73.00
		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
90.00	09000	CLINIC	0.000000	1,935	0	2,207,536	0	90.00
91.00	09100	EMERGENCY	0.000000	3,542,652	0	7,704,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,083	0	698,367	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	361,915	0	1,578,468	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		19,776,956	0	73,298,789	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.123891	12,571,924	0	0	1,557,548	50.00
53.00	05300	ANESTHESIOLOGY	0.755779	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214074	5,432,448	0	0	1,162,946	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.188539	6,411,814	0	0	1,208,877	56.01
57.00	05700	CT SCAN	0.060830	5,246,522	0	0	319,146	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117599	2,276,258	0	0	267,686	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.169743	3,308,775	1,530	0	561,641	60.00
65.00	06500	RESPIRATORY THERAPY	0.261367	421,480	0	0	110,161	65.00
65.01	06501	SLEEP LAB	0.258491	577,596	5,916	0	149,303	65.01
66.00	06600	PHYSICAL THERAPY	0.442347	45,978	0	0	20,338	66.00
69.00	06900	ELECTROCARDIOLOGY	0.158993	3,737,272	0	0	594,200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.289632	2,590,760	0	0	750,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278296	18,488,626	0	100,855	5,145,311	73.00
		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
90.00	09000	CLINIC	0.482391	2,207,536	0	0	1,064,895	90.00
91.00	09100	EMERGENCY	0.107018	7,704,965	0	0	824,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.018263	698,367	0	0	711,121	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.325250	1,578,468	345	0	513,397	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		73,298,789	7,791	100,855	14,961,507	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		73,298,789	7,791	100,855	14,961,507	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	0	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	260	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	1,529	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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 PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,068	73.00
	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
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	112	0	92.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,901	28,068	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,901	28,068	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,248	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,248	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)	7,910	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,463	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,918,048	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,918,048	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)	14,918,048	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,613.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,973,090	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,973,090	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/15/2023 9:14 am
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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,646,818	1,806	2,572.99	387	995,747	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,709,315	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)	8,678,152	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)	380,509	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	206,081	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	586,590	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,091,562	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)	1,338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,613.11	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/15/2023 9:14 am
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	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,158,341	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,222,089	14,918,048	0.081920	2,158,341	176,811	90.00
91.00	Nursing Program cost	0	14,918,048	0.000000	2,158,341	0	91.00
92.00	Allied health cost	0	14,918,048	0.000000	2,158,341	0	92.00
93.00	All other Medical Education	0	14,918,048	0.000000	2,158,341	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/15/2023 9:14 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,248	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,248	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)	7,910	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	271	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,918,048	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,918,048	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)	14,918,048	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,613.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	437,153	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)	437,153	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/15/2023 9:14 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,646,818	1,806	2,572.99	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	377,804	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)	814,957	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)	1,338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,613.11	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/15/2023 9:14 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,158,341	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,222,089	14,918,048	0.081920	2,158,341	176,811	90.00
91.00	Nursing Program cost	0	14,918,048	0.000000	2,158,341	0	91.00
92.00	Allied health cost	0	14,918,048	0.000000	2,158,341	0	92.00
93.00	All other Medical Education	0	14,918,048	0.000000	2,158,341	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,733,682		30.00
31.00	03100	INTENSIVE CARE UNIT		1,487,286		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123891	2,257,000	279,622	50.00
53.00	05300	ANESTHESIOLOGY	1.337422	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214074	978,852	209,547	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.188746	80,683	15,229	56.01
57.00	05700	CT SCAN	0.060830	1,824,264	110,970	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117599	302,802	35,609	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.171794	2,632,115	452,182	60.00
65.00	06500	RESPIRATORY THERAPY	0.261367	2,689,977	703,071	65.00
65.01	06501	SLEEP LAB	0.258491	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.442347	483,573	213,907	66.00
69.00	06900	ELECTROCARDIOLOGY	0.158993	893,660	142,086	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.289632	643,766	186,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278296	3,078,679	856,784	73.00
		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
90.00	09000	CLINIC	0.482391	1,935	933	90.00
91.00	09100	EMERGENCY	0.107273	3,542,652	380,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.018263	5,083	5,176	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.325250	361,915	117,713	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,776,956	3,709,315	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)		19,776,956		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/15/2023 9:14 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		339,276		30.00
31.00	03100	INTENSIVE CARE UNIT		441,483		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123891	289,175	35,826	50.00
53.00	05300	ANESTHESIOLOGY	0.755779	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214074	62,733	13,430	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.188539	0	0	56.01
57.00	05700	CT SCAN	0.060830	96,702	5,882	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117599	71	8	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.169743	179,582	30,483	60.00
65.00	06500	RESPIRATORY THERAPY	0.261367	478,836	125,152	65.00
65.01	06501	SLEEP LAB	0.258491	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.442347	11,823	5,230	66.00
69.00	06900	ELECTROCARDIOLOGY	0.158993	40,000	6,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.289632	16,912	4,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278296	346,586	96,453	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.138816	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.114198	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.096734	0	0	88.02
90.00	09000	CLINIC	0.482391	0	0	90.00
91.00	09100	EMERGENCY	0.107018	221,001	23,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.018263	1,850	1,884	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.325250	87,770	28,547	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,833,041	377,804	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,833,041		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Prepared: 5/15/2023 9:14 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,043,245	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,314,900	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	12,123	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	42.32	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.61	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.75	31.00
32.00	Sum of lines 30 and 31	27.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.79	33.00

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			1.00	
34.00	Disproportionate share adjustment (see instructions)		187,407	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	868,613	934,613	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	649,675	235,574	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	885,249		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,442,924		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,442,924	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	474,793	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	13,390	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,931,107	59.00
60.00	Primary payer payments	16,814	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,914,293	61.00
62.00	Deductibles billed to program beneficiaries	851,896	62.00
63.00	Coinsurance billed to program beneficiaries	1,167	63.00
64.00	Allowable bad debts (see instructions)	90,543	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	58,853	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,451	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,120,083	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-52,660	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/15/2023 9:14 am
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	526,549	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	151,511	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		67,238	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,678,245	71.00
71.01	Sequestration adjustment (see instructions)		96,746	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		7,221,641	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		359,858	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		131,487	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/15/2023 9:14 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,043,245	0	5,043,245		5,043,245	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,314,900	0		1,314,900	1,314,900	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	12,123	0	12,123		12,123	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1179	0.1179	0.1179	0.1179		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	187,407	0	148,650	38,757	187,407	11.00
11.01	Uncompensated care payments	36.00	885,249	0	649,675	235,574	885,249	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,442,924	0	5,853,693	1,589,231	7,442,924	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,442,924	0	5,853,693	1,589,231	7,442,924	15.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	474,793	0	377,717	97,076	474,793	16.00
17.00	Special add-on payments for new technologies	54.00	13,390	0	13,390	0	13,390	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,244,800	1,686,307	7,931,107	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	473,897	0	376,821	97,076	473,897	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	896	0	896	0	896	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	474,793	0	377,717	97,076	474,793	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.084318	0.089848		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			526,549		526,549	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				151,511	151,511	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 | Date/Time Prepared: 5/15/2023 9:14 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,043,245	5,043,245		5,043,245	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,314,900		1,314,900	1,314,900	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	12,123	12,123		12,123	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1179	0.1179	0.1179		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	187,407	148,650	38,757	187,407	11.00
11.01	Uncompensated care payments	36.00	885,249	649,675	235,574	885,249	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,442,924	5,853,693	1,589,231	7,442,924	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,442,924	5,853,693	1,589,231	7,442,924	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	474,793	377,717	97,076	474,793	16.00
17.00	Special add-on payments for new technologies	54.00	13,390	13,390	0	13,390	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,244,800	1,686,307	7,931,107	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/15/2023 9:14 am
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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	473,897	376,821	97,076	473,897	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	896	896	0	896	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	474,793	377,717	97,076	474,793	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	526,549	526,549		526,549	28.00
29.00	Low volume adjustment on or after October 1	70.97	151,511		151,511	151,511	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-52,660	-47,532	-5,128	-52,660	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		67,238	0	67,238	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/15/2023 9:14 am

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	29,969	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,961,507	2.00
3.00	OPPS payments	11,767,114	3.00
4.00	Outlier payment (see instructions)	66,214	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)	29,969	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	108,646	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)	108,646	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)	108,646	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	78,677	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)	29,969	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)	11,833,328	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	1,252	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,144,419	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)	9,717,626	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)	9,717,626	30.00
31.00	Primary payer payments	2,235	31.00
32.00	Subtotal (line 30 minus line 31)	9,715,391	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)	193,243	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	125,608	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	114,460	36.00
37.00	Subtotal (see instructions)	9,840,999	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-79	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)	9,841,078	40.00
40.01	Sequestration adjustment (see instructions)	123,998	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	9,750,918	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)	-33,838	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: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/15/2023 9:14 am
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		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: 15-0097

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

Worksheet E-1 Part I

Date/Time Prepared: 5/15/2023 9:14 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,156,612		9,586,111	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	12/31/2022	65,029	12/31/2022	164,807	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)		65,029		164,807	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)		7,221,641		9,750,918	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		359,858		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		33,838	6.02
7.00	Total Medicare program liability (see instructions)		7,581,499		9,717,080	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: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 5/15/2023 9:14 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	814,957		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	814,957	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	814,957	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	780,759		8.00
9.00	Ancillary service charges	1,833,041	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,613,800	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,613,800	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,798,843	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	814,957	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	814,957	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	814,957	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	5,771	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)	809,186	0	36.00
37.00	OTHER ADJUSTMENTS	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	809,186	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)	809,186	0	40.00
41.00	Interim payments	1,017,095	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-207,909	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII		PPS

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

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

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/15/2023 9:14 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-870,779	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	52,100,465	0	0	0	4.00
5.00	Other receivable	10,297,649	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-36,080,717	0	0	0	6.00
7.00	Inventory	5,520,381	0	0	0	7.00
8.00	Prepaid expenses	2,785,950	0	0	0	8.00
9.00	Other current assets	4,221	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)	33,757,170	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,900,662	0	0	0	12.00
13.00	Land improvements	12,792,242	0	0	0	13.00
14.00	Accumulated depreciation	-5,915,882	0	0	0	14.00
15.00	Buildings	147,116,985	0	0	0	15.00
16.00	Accumulated depreciation	-36,661,527	0	0	0	16.00
17.00	Leasehold improvements	264,162	0	0	0	17.00
18.00	Accumulated depreciation	-253,009	0	0	0	18.00
19.00	Fixed equipment	6,966,805	0	0	0	19.00
20.00	Accumulated depreciation	-3,259,059	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	61,008,182	0	0	0	23.00
24.00	Accumulated depreciation	-42,863,109	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)	142,096,452	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,859,024	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	384,207,598	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	386,066,622	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	561,920,244	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,821,585	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,313,105	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	97,257,631	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	114,392,321	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	89,853,531	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	89,853,531	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	204,245,852	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	357,674,392				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)	357,674,392	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	561,920,244	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 Date/Time Prepared: 5/15/2023 9:14 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		364,449,822		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,775,430				2.00
3.00	Total (sum of line 1 and line 2)		357,674,392		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		357,674,392		0		11.00
12.00	ROUNDING	678		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)		678		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		357,673,714		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			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	ROUNDING		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: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/15/2023 9:14 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,390,780		15,390,780	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER (SPECIFY)				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)	15,390,780		15,390,780	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,738,934		6,738,934	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)	6,738,934		6,738,934	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,129,714		22,129,714	17.00
18.00	Ancillary services	70,050,496	409,591,768	479,642,264	18.00
19.00	Outpatient services	0	43,343	43,343	19.00
20.00	RURAL HEALTH CLINIC	0	4,730,452	4,730,452	20.00
20.01	RURAL HEALTH CLINIC II	0	2,610,022	2,610,022	20.01
20.02	RURAL HEALTH CLINIC III	0	19,044,558	19,044,558	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
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)	92,180,210	436,020,143	528,200,353	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		171,358,783		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		171,358,783		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/15/2023 9:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	528,200,353	1.00
2.00	Less contractual allowances and discounts on patients' accounts	371,276,488	2.00
3.00	Net patient revenues (line 1 minus line 2)	156,923,865	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	171,358,783	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,434,918	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 OPERATING INCOME	7,659,488	24.00
24.01	OTHER REVENUE	0	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,659,488	25.00
26.00	Total (line 5 plus line 25)	-6,775,430	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)	-6,775,430	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0097	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	473,897	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	896	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	26.78	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	474,793	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/15/2023 9:14 am

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	264,683	719,777	984,460	70,630	1,055,090	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	114,285	0	114,285	0	114,285	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	27,187	0	27,187	0	27,187	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	851,993	0	851,993	0	851,993	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,258,148	719,777	1,977,925	70,630	2,048,555	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	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	382,274	382,274	0	382,274	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	382,274	382,274	0	382,274	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,258,148	1,102,051	2,360,199	70,630	2,430,829	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	63,915	63,915	0	63,915	29.00
30.00	Administrative Costs	211,325	118,377	329,702	0	329,702	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	211,325	182,292	393,617	0	393,617	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,469,473	1,284,343	2,753,816	70,630	2,824,446	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8529 | Date/Time Prepared: 5/15/2023 9:14 am

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	122,405	1,177,495	1.00
2.00	Physician Assistant	129,366	129,366	2.00
3.00	Nurse Practitioner	267,669	381,954	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	27,187	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	851,993	9.00
10.00	Subtotal (sum of lines 1 through 9)	519,440	2,567,995	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	382,274	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	382,274	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	519,440	2,950,269	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	63,915	29.00
30.00	Administrative Costs	321,513	651,215	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	321,513	715,130	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	840,953	3,665,399	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/15/2023 9:14 am

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	0	607,337	607,337	0	607,337	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	125,289	0	125,289	0	125,289	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	94,434	0	94,434	0	94,434	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	307,035	0	307,035	0	307,035	9.00
10.00	Subtotal (sum of lines 1 through 9)	526,758	607,337	1,134,095	0	1,134,095	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	345,749	345,749	0	345,749	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	345,749	345,749	0	345,749	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	526,758	953,086	1,479,844	0	1,479,844	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	225,262	225,262	0	225,262	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	225,262	225,262	0	225,262	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,898	17,898	0	17,898	29.00
30.00	Administrative Costs	204,706	88,133	292,839	0	292,839	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	204,706	106,031	310,737	0	310,737	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	731,464	1,284,379	2,015,843	0	2,015,843	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1
Component CCN: 15-8531 | Date/Time Prepared: 5/15/2023 9:14 am

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	23,078	630,415	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	125,289	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	94,434	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	307,035	9.00
10.00	Subtotal (sum of lines 1 through 9)	23,078	1,157,173	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	345,749	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	345,749	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	23,078	1,502,922	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	-225,262	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-225,262	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	17,898	29.00
30.00	Administrative Costs	159,793	452,632	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	159,793	470,530	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,391	1,973,452	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/15/2023 9:14 am

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	800,665	3,139,507	3,940,172	0	3,940,172	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	227,135	240	227,375	0	227,375	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	3,866	3,866	0	3,866	6.00
7.00	Clinical Social Worker	109,468	0	109,468	0	109,468	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	3,172,524	0	3,172,524	0	3,172,524	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,309,792	3,143,613	7,453,405	0	7,453,405	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	254,241	1,098,783	1,353,024	0	1,353,024	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	254,241	1,098,783	1,353,024	0	1,353,024	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,564,033	4,242,396	8,806,429	0	8,806,429	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	508,635	508,635	0	508,635	29.00
30.00	Administrative Costs	1,663,507	677,343	2,340,850	0	2,340,850	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,663,507	1,185,978	2,849,485	0	2,849,485	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	6,227,540	5,428,374	11,655,914	0	11,655,914	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/15/2023 9:14 am

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-236,166	3,704,006	1.00
2.00	Physician Assistant	185,900	185,900	2.00
3.00	Nurse Practitioner	1,740,391	1,967,766	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	3,866	6.00
7.00	Clinical Social Worker	0	109,468	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	3,172,524	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,690,125	9,143,530	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	1,353,024	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,353,024	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,690,125	10,496,554	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	508,635	29.00
30.00	Administrative Costs	1,030,422	3,371,272	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,030,422	3,879,907	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,720,547	14,376,461	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2022 To 12/31/2022	Worksheet M-2 Date/Time Prepared: 5/15/2023 9:14 am
		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	4.05	9,075	1	4		1.00
2.00	Physician Assistant	1.00	2,899	1	1		2.00
3.00	Nurse Practitioner	3.07	9,368	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.12	21,342		8	21,342	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	0.30	1,417			1,417	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.42	22,759			22,759	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,950,269	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,950,269	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)	715,130	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,721,714	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,436,844	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,436,844	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,436,844	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	5,387,113	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2022 To 12/31/2022	Worksheet M-2 Date/Time Prepared: 5/15/2023 9:14 am
		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	1.74	6,149	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.93	2,435	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.67	8,584		3	8,584	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	1.15	42			42	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)	3.82	8,626			8,626	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)	1,502,922	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)	1,502,922	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)	470,530	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	935,386	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,405,916	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,405,916	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,405,916	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,908,838	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0097 | Component CCN: 15-8532 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/15/2023 9:14 am

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	11.00	32,680	1	11		1.00
2.00	Physician Assistant	1.00	2,694	1	1		2.00
3.00	Nurse Practitioner	14.03	30,290	1	14		3.00
4.00	Subtotal (sum of lines 1 through 3)	26.03	65,664		26	65,664	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	1.32	301			301	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)	27.35	65,965			65,965	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)	10,496,554	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)	10,496,554	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)	3,879,907	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	6,510,345	15.00
16.00	Total overhead (sum of lines 14 and 15)	10,390,252	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	10,390,252	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	10,390,252	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	20,886,806	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/15/2023 9:14 am
	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)		5,387,113	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		413,882	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		4,973,231	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		22,759	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)		22,759	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		218.52	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	254.21	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	218.52	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	31	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	6,774	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	6,774	16.00
16.01	Total program charges (see instructions)(from contractor's records)		5,425	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		5,380	16.04
16.05	Total program cost (see instructions)	0	5,380	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,075	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		5,380	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		5,380	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)		5,380	26.00
26.01	Sequestration adjustment (see instructions)		67	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		6,174	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)		-861	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: 15-0097 Component CCN: 15-8531	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/15/2023 9:14 am
	Title XVIII	RHC II	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,908,838	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		1,725	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,907,113	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,626	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)		8,626	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		337.02	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	458.26	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	337.02	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	204	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,752	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	68,752	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,757	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,088	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,669	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.)		37,828	16.04
16.05	Total program cost (see instructions)	0	57,497	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,798	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,174	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		57,497	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		230	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		57,727	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)		57,727	26.00
26.01	Sequestration adjustment (see instructions)		727	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		77,924	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)		-20,924	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: 15-0097 Component CCN: 15-8532	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/15/2023 9:14 am	
Title XVIII	RHC III		

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)		20,886,806	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		628,527	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		20,258,279	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		65,965	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)		65,965	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		307.11	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	352.05	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	307.11	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	14,811	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	4,548,606	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	19	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	5,835	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	5,835	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	4,554,441	16.00
16.01	Total program charges (see instructions)(from contractor's records)		3,697,056	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		697,867	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		859,710	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.)		2,767,556	16.04
16.05	Total program cost (see instructions)	0	3,627,266	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		235,286	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		552,781	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,627,266	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		161,270	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,788,536	22.00
23.00	Allowable bad debts (see instructions)		11,887	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		7,727	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,653	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)		3,796,263	26.00
26.01	Sequestration adjustment (see instructions)		47,833	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		4,054,487	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)		-306,057	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: 15-0097 | Component CCN: 15-8529 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/15/2023 9:14 am

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)	2,567,995	2,567,995	2,567,995	2,567,995	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005114	0.003240	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	13,133	8,320	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	156,178	49,033	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	169,311	57,353	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,950,269	2,950,269	2,950,269	2,950,269	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,436,844	2,436,844	2,436,844	2,436,844	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.057388	0.019440	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	139,846	47,372	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	309,157	104,725	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,572	996	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	196.66	105.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	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)	0	0	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)		413,882	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)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-0097 Component CCN: 15-8531	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/15/2023 9:14 am
	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)	1,157,173	1,157,173	1,157,173	1,157,173	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000132	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	153	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	738	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	891	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,502,922	1,502,922	1,502,922	1,502,922	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,405,916	1,405,916	1,405,916	1,405,916	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000593	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	834	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	1,725	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	15	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	115.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	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)	0	230	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)		1,725	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)		230	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-0097 Component CCN: 15-8532	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/15/2023 9:14 am
	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)	9,143,530	9,143,530	9,143,530	9,143,530	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000521	0.004098	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,764	37,470	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	55,835	217,794	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	60,599	255,264	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	10,496,554	10,496,554	10,496,554	10,496,554	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	10,390,252	10,390,252	10,390,252	10,390,252	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005773	0.024319	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	59,983	252,681	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	120,582	507,945	0	0	10.00
11.00	Total number of injections/infusions (from your records)	562	4,424	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	214.56	114.82	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	171	1,085	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)	36,690	124,580	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)		628,527	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)		161,270	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0097 Component CCN: 15-8529	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/15/2023 9:14 am
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		6,174	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)		6,174	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		861	6.02
7.00	Total Medicare program liability (see instructions)		5,313	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: 15-0097 | Component CCN: 15-8531 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/15/2023 9:14 am

RHC II

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		77,924	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)		77,924	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		20,924	6.02
7.00	Total Medicare program liability (see instructions)		57,000	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: 15-0097 Component CCN: 15-8532	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/15/2023 9:14 am
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		4,054,487	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)		4,054,487	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		306,057	6.02
7.00	Total Medicare program liability (see instructions)		3,748,430	7.00

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